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VOLUME 32

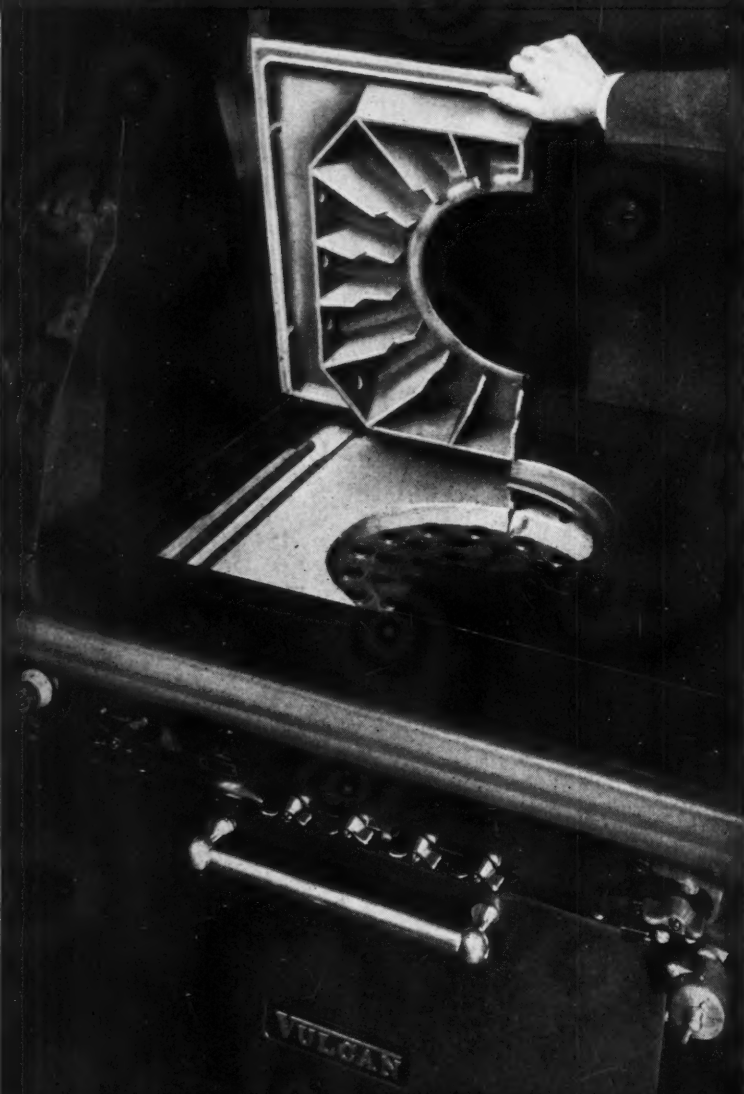
FEBRUARY 1939

NUMBER 2

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For February 1939

Just in Passing—

**Cover Page**—Entrance to one wing, Columbia Hospital, Milwaukee, designed by WILLIAM SCHUCHARDT, now of California.

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IF YOU have been following each month the rising total of hospital construction projects as given in the Hospital Barometer (page 8), you are aware that last year witnessed a large upturn in hospital building. The total sum involved was nearly \$150,000,000, by far the largest of any postdepression year. Even this sum, however, is not large enough to equal the predepression average. More important, it is probably not large enough to keep our present hospital plant ahead of its natural obsolescence, the growth of population, the advance of the clinical and engineering sciences and still to make any appreciable dent in the deficit of hospital construction that accumulated during the depression.

Average hospital occupancy maintained a good level during 1938. Some hospitals, indeed, are approaching, if they have not exceeded, the practicable maximum limits of occupancy. This forces them to consider further expansion.

EXAMINATION of the recent figures and present trends leads us to believe that 1939 will witness more hospital construction than did 1938. Hence the March building and equipment number will be especially timely this year. It will be packed with good material. A special 32 page supplement will contain planning and construction stories exclusively.

One construction article deals with planning the emergency entrance and the accident room. This is by Perry W. Swern, hospital architect of Chicago. The second of three articles on the planning of new mental hospital facilities in Missouri will follow. The first article in this well-prepared series is in the issue you have in your hands (page 61).

"Infections Challenge Planning" is the intriguing title of an article for March by Dr. J. J. Golub, hospital adminis-

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trator and consultant. The whole series of problems relating to the planning of x-ray departments is carefully stated and summarized by William A. Riley of Stevens, Curtin and Mason, architects, Boston. An unusual article on the planning of tuberculosis hospitals will appear under the signature of Russell Guerne deLappe of Oakland, Calif.

**T**HE entire issue will not, of course, be devoted to planning. The department of hospital pharmacy, which starts this month on page 102, also will present excellent articles in March. One will indicate ways of eliminating obsolete drugs from the pharmacy's shelves and will give suggestions for preventing their accumulation. Another will suggest a satisfactory method of pricing prescriptions. We especially commend to your attention in this and succeeding issues of the pharmacy department Doctor Pfeiffer's clinical notes and abstracts. Interns, residents and staff men will be interested as well as pharmacists.

**I**N HIS will the late Senator Phelan of California bequeathed money to be used for the benefit of the bedridden patient. This humanitarian objective is being carried out by his trustees and the first report on achievements under the will is to appear in our March issue. Two physicians of the University of California Medical School have studied intensively the ordinary hospital bedpan and have radically improved it. Administrators and nurses will be keenly interested in their results.

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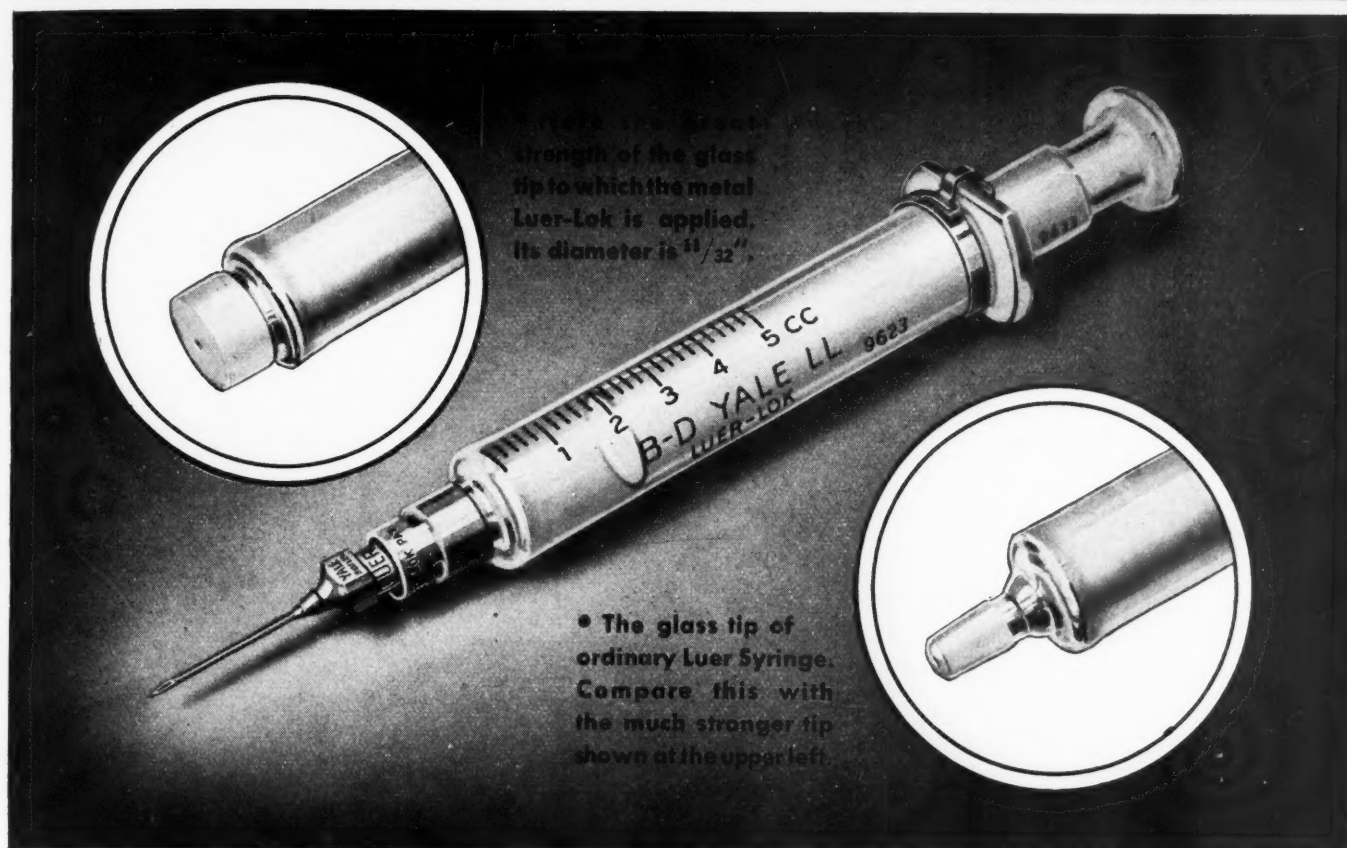
Institutional pharmacy is growing up and needs a suitable mouthpiece. This editorial introduces a new department designed to fill that need.

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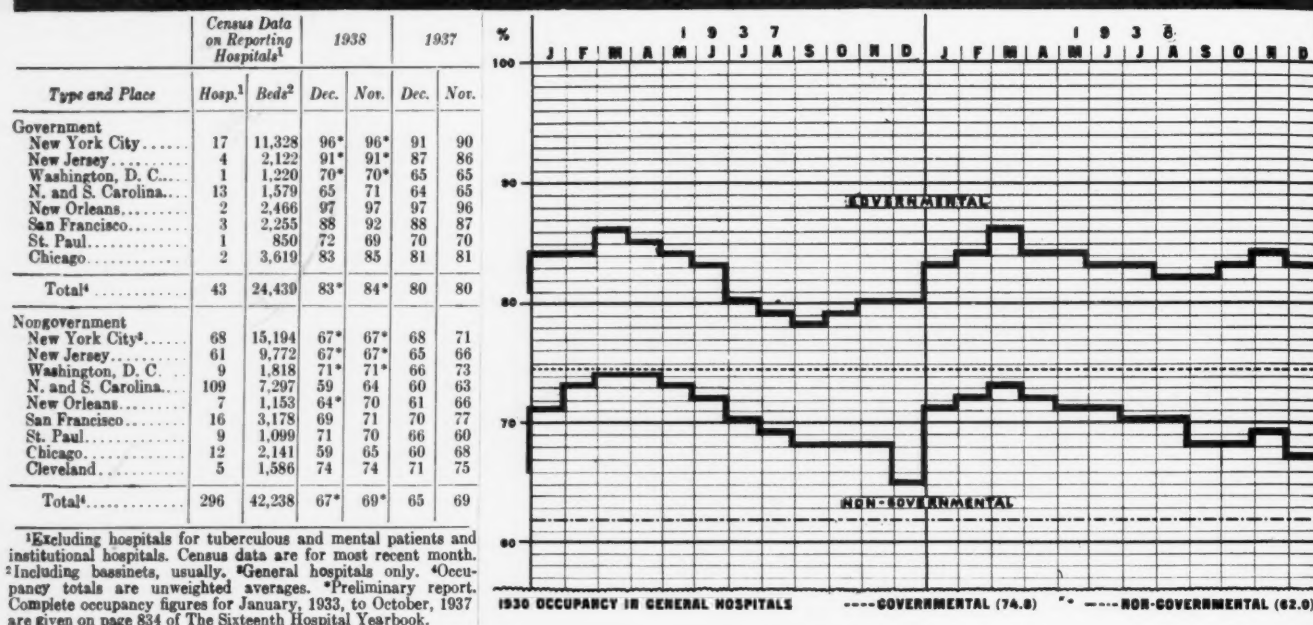
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## HOSPITAL OCCUPANCY BAROMETER



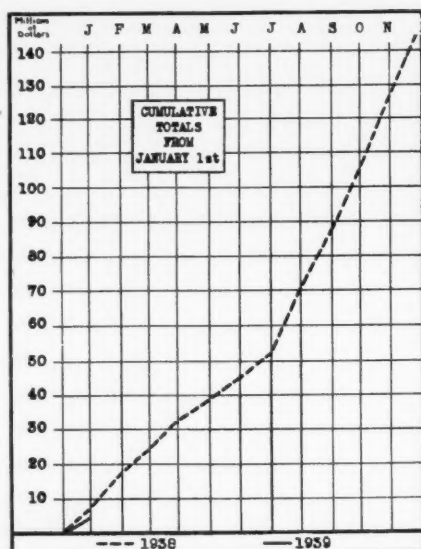
## Usual Holiday Slump in Occupancy But Year's Total Is High

The occupancy in voluntary general hospitals dropped two points in December, according to preliminary reports. This is in accord with the usual fall in occupancy during the holidays but the figure is still at a higher level than was recorded for December 1937.

For the entire year 1938, the occupancy in voluntary hospitals was 70.1 per cent, which is a slight decrease from the record-breaking occupancy total of 70.6 reported by these hospitals last year. (This figure agrees closely with the 1937 total of 69.7 reported by the American Medical Association for all nonprofit hospitals. This was the highest occupancy figure reported since the association began gathering such statistics.) The figures given above for The MODERN HOSPITAL reports may be compared with annual totals of 66.5 for 1936; 61.2 for 1935; 57.8 for 1934, and 54.3 for 1933. Thus in five years voluntary hospital occupancy has increased by 16 points.

For governmental hospitals also there was a slight drop in occupancy in December. But, like the voluntary hospitals, the governmental institutions ended the year with a higher occupancy than was recorded for corresponding months in 1937. The total occupancy of these institutions for the

## HOSPITAL CONSTRUCTION



year was 83.4 per cent. In 1937 it was 81.8; in 1936, 86.6; in 1935, 85.8; in 1934, 87.7, and in 1933, 85.5. Thus there has been some decrease in the overcrowded conditions in governmental hospitals since 1934 but apparently the trend has swung up again.

Hospital construction during the period from December 19 to January

16 was relatively light, only \$4,841,000 of new projects being announced during these four weeks. There were 38 projects in the list, only 36 of which reported costs. Six new hospitals were included; five of these reported costs which aggregate \$289,369. There were 32 additions to existing hospitals, of which 31 reported costs totaling \$4,556,454.

The general wholesale price index of the *New York Journal of Commerce* advanced from 74.7 on December 19 to 75.3 on January 23. Grain prices made a rapid advance during the period, going from 55.7 at the beginning to a high of 59.7 on January 9 and then dropping off to 58.8. Food prices also advanced from 65.9 to 66.8 in the five weeks. Textile and building materials showed slight advances, the former going from 53.6 to 54.1 and the latter from 97.1 to 97.8. Fuel remained unchanged at 82.1, having decreased to this figure in the preceding four week period. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter* remained practically unchanged at 182.6 during the period. (The latter index is based on prices as of August 1, 1914, while the indices of the *New York Journal of Commerce* are based on 1927-29 prices.)

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## WITH THE ROVING REPORTER

### Gift Suggestions

- Many visitors to Passavant Memorial Hospital, Chicago, inquire about the calendar panel on the wall of the reception lobby. Well, here's the story.

It has been established by the Woman's Aid Society and they call it the Memorial Calendar. Anyone who wants to honor a certain day in commemoration of a relative or friend can arrange to have a gold card, 7 by 15 inches, placed in the panel on which the name of the person honored is hand lettered in India ink. If it is the wish of the donor, proper notice will be sent to the family of the individual in whose memory the donation is made.

Here is another suggestion by which people may contribute to the support of the hospital. A donation may be given to the hospital instead of sending flowers to funeral services. An appropriate notice is sent to the family of the one in whose memory this gift is made.

Incidentally, these suggestions are presented in the hospital's new quarterly review which made its first appearance in December. "The purpose of this publication is to report the continuing services and activities of the hospital to former patients, as well as to those who have most generously contributed both material and spiritual benefits."

### Suggestions for Noise

- Should any unusual noise produced by renovations or a new building program make it even more difficult than usual to carry on, why not do as Mary G. McPherson, administrator at Ellis Hospital, Schenectady, N. Y., did and explain the situation frankly to patients.

When construction work started on the new building, she prepared the following notice.

"We want to talk to you about your visit with us. We hope that we can make you as comfortable as possible. We shall try very hard. Everyone here is interested in your rapid recovery. You probably know that we have already started upon our building program. Considerable preliminary work has already been done. We have been glad to find that few patients have been disturbed thus far; and the con-

tractors are cooperating in every way.

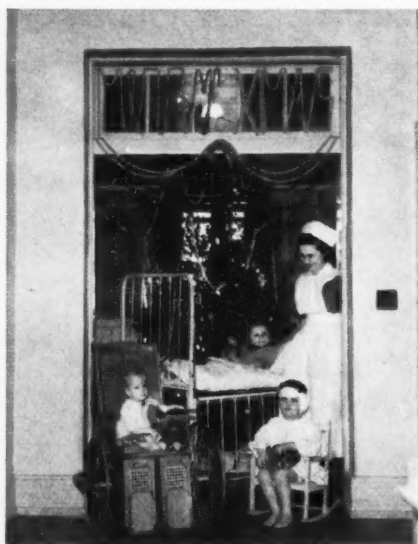
"If you are disturbed by noises, will you please talk with your supervising nurse, who will do everything she can to make the noise less disturbing."

### They Help Themselves

- What's all this going on in the children's division of the University of Virginia Hospital, University, Va.? It wasn't the day before Christmas, but several days before, and the chances are you never saw a busier, happier place—every little patient hard at work helping make decorations for the tree.

You see that fireplace, a professional looking job if there ever was one? Well, the boys helped build it. Every one of the children contributed something to the crèche. Too bad we can't stay long enough to share the excitement of Christmas morning.

If you inquire about it all, Clare M. J. Wangen, superintendent of nurses, will tell you that the children are learning to help each other because it has been discovered that when they help others they forget their own grief and loneliness. They are not



forced to play but enter into it spontaneously, of their own accord, and are encouraged to choose their own type of play. Everything possible is done to stress the normal home atmosphere. The children wear simple colored dresses, for example, instead of the regulation hospital clothes.

No one has to tell you anything about the success of this treatment.

### Children Tell the Story

- Speaking about children in the hospital and the way they are treated, there couldn't have been a better demonstration than that staged recently at the New Jersey Orthopedic Hospital, Orange, N. J. It comprised part of the program of the annual meeting of the board of trustees, arranged by Ruth Coon, superintendent, and her staff.

The histories of two or three of the little patients were revealed by Dr. Harold W. Smith to a small audience of hospital board members, doctors and a few invited guests through x-ray films. Then the patients themselves were introduced, several of them no longer hospitalized but glad to appear in person to demonstrate the remarkable flexibility of what once were badly crippled backs or hips.

It was the little crippled girl, flat on her back on her rolling bed, who won the audience, however. From beneath her coverlet she produced mysteriously a guitar on which she strummed quite professionally an accompaniment to the young tenor of 12 or 13 standing by her side in his bathrobe. During the weeks of their hospitalization the two discovered they had musical talents in common and had entertained each other as well as their fellow patients, to say nothing of the hospital personnel.

They gave the trustees a treat, too, proving conclusively that even hospital life has its happier side.

### Internships in Pharmacy

- In the past few years a great change has been made in the curriculums in the schools of pharmacy throughout the country. Curriculums have been revised and additional courses added, the move being made with a view toward courses of more intrinsic value.

R. M. Porter, assistant administrator, City Hospital, Akron, Ohio, points out that a number of schools have turned their thoughts toward hospital pharmacies, realizing that with the growing importance of the pharmacy in hospitals there is an increasing demand that pharmacists be trained in a specialty. Many pharmacy educators realize that much of this training must be done in the hospital itself. A number of hospitals also realize that the pharmacist, recently graduated from a school of pharmacy, does not have all the prerequisites necessary to his job. As a result, a number of hospitals have developed internships in pharmacy.



# LOOKING FORWARD

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## Social Security for Employes

THE Advisory Council on Social Security has recommended to Congress and the President that the old age insurance program of the Social Security Act be extended immediately to apply to employes of "private nonprofit religious, charitable and educational institutions now excluded from coverage." It has also recommended that "studies should be made of the administrative, legal and financial problems involved in the coverage of . . . governmental employes." Unemployment insurance is not mentioned for either group.

The time has probably come when the voluntary hospitals of America should withdraw their opposition to the old age insurance for their employes. The better class of employes wants this protection and will not so readily take employment in an institution in which it is denied them. Hospitals should acquiesce gracefully rather than have this change forced upon them by employe and public pressure.

It is only fair to point out, however, that if old age insurance is desirable for the employes of voluntary hospitals it is just exactly as desirable for the employes of governmental hospitals. If Congress will give similar treatment to both types of hospital, opposition to the program will be minimized. Somehow the hospitals will find the funds to meet this added obligation.

## Hospital Staffs and Group Plans

IT IS interesting to observe that those very physicians who recently branded hospital care insurance plans as the beginning of the practice of socialized medicine now hurry forward with their applications to join and thus to protect themselves and their families from the crippling cost of illness.

No doubt the great interest in hospital care insurance shown by hospital staffs not only for their patients but also for themselves results from wider knowledge of the details of such plans as well as a release from what the physician has considered his duty to organized medicine. Until recently, it has been the policy of many medical organizations to oppose hospitalization plans but to offer no substitute.

Whether staffs should join group plans depends largely upon the arrangements made for the care of sick personnel in the individual hospital. If hospital costs are franked or even strongly discounted, perhaps the physician will save little by enrolling in a group plan. If his family is not given hospital care with equal discounts, to join a group plan will save a physician money. The hospital that can enroll its staff early will do well because it is conceivable that with the present system of multiple staff appointments some institutions may not be able to muster the required percentage of staff applications.

## Pity the Poor President

A STATE hospital association has two principal functions. One is to hold a convention at which hospital administrators and others may learn the best current thought concerning hospital work. The other is to carry on those activities that concern all hospitals of the state. These include legislative matters, relations with medical and nursing groups and other public relations policies and activities.

Many state hospital associations have discovered that these two activities are quite different in character. The first mentioned responsibility is primarily educational. It is most successful when the national leaders of hospital thought are present to share their experience and observation with the assembled administrators. The second is usually entirely local and can best be handled in small local groups which can concentrate on the problem at hand without any distracting papers, addresses and entertainment of visiting notables.

The obvious answer is to separate the two activities. Let the educational function be carried on by regional hospital associations or assemblies that serve three or more states. Already there are six of these regional units, which put on excellent programs and exhibits. Others should be formed.

For legislative and similar work a one day meeting of a state association or, even better, a series of local district meetings attended by the officers of the state association seems to be the most fruitful method.

An incidental benefit of such a development is that it relieves, to some extent, the enormous load which is

put upon the officers of national hospital associations. Even now the president of the American Hospital Association is expected to attend six regional meetings and 20 state and provincial meetings. In addition, there are the national and sectional meetings of the American College of Surgeons, the national meetings of various other medical associations and the convention of the American Hospital Association itself. These are in addition to the many meetings of the A.H.A. board of trustees, the coordinating council, the joint committee on national legislation and occasional meetings of other important committees. The load is terrific on any man who attempts to administer a hospital during his term of office.

## Infant Mortality and the Hospital

ACCORDING to recent mortality statistics released by a great insurance company, the life expectancy for white persons in the United States is five and one-half years lower than that in New Zealand. In the United States the death rate from infant digestive disturbances is five times as great as in the latter country. Infant deaths from premature birth and injury at birth are particularly high in America.

Many of these calamities are preventable. It is not difficult to understand the effect on life expectancy of an unusually high infant mortality. The hospital must bear its part of the responsibility for this distressing condition. Too little attention is paid to morbidity and infant mortality statistics in the maternity department. The courtesy staff is often improperly selected and supervised. In some cases the physical arrangements for the maternity division make complete separation from general hospital activities impossible.

Since a large percentage of births in the United States takes place in the hospitals, the work of lessening the hazards of childbirth should begin there. To this end the board of trustees should carefully scrutinize the results of the work of staff and nurses in the obstetrical department. No maternal deaths and the absolute minimum of stillbirths should be the goal most strenuously sought.

## Hospital Etiquette and Gravity

NURSES are taught to stand when physicians enter the room in which they are working. This is a proper evidence of respect and is usually devoid of any personal implications. Physicians are not so careful to carry their drawing room manners into their hospital lives. Whether it is good form for a doctor to sit down while talking to a nurse is a matter of opinion. Certainly it is a nice gesture for the physician to allow the nurse to precede him through room and elevator doors. At times, however, the force of gravity appears to overwhelm a nurse or an orderly

when a physician approaches. By the same token interns often seem to be powerless to rise when their seniors approach a ward desk. Surely the niceties of institutional etiquette should not be confined wholly to the members of the school of nursing.

## Sample Collectors

ALL men may be divided into two types: ordinary citizens and "string savers." To the latter throwing away anything, no matter how useless, is a cardinal sin. Hospital executives of this class have storerooms and every out of the way place bulging with discarded apparatus and materials of all descriptions.

Then there are the administrators who write for samples of supplies and equipment that they have not the least idea of purchasing for the hospital. The sample evil is one that certainly adds to the cost of drugs and probably to all types of hospital supplies introduced in this way.

It is hardly honest to request a sample of some type of rubber goods, catgut or surgeon's gown, for example, unless a purchase is at least contemplated. This practice is as questionable as that of the manufacturer who gives a new obstetrical bed or ultraviolet apparatus to a leading hospital so that his advertising literature may state that this equipment is in use in the institution in question. Straight dealing requires that no untruths be deliberately uttered or even implied.

## Gift Funds

WHEN illness befalls a relative or a friend many people show their sympathy by sending flowers or other gifts. Such acts are often most heartening to the patient. When, unfortunately, death enters a family circle a time-honored, if slightly threadbare, tradition dictates the sending of floral tributes alone. When a person of prominence passes, many hundreds or even thousands of dollars are spent for flowers which often remain on view but a few hours.

In the presence of great need everywhere, many people today doubt the wisdom of allowing the expense of such emotional outbursts to mount as it has. They say that it is money thrown away or at best spent to dull the edge of grief by catering to the pride of the family and friends.

Here and there one observes a community which has solved this problem. Instead of flowers, books, candy and lingerie for the sick and floral tributes for the deceased there comes a dignified engraved announcement that a friend has contributed a stated or unstated sum to the hospital free bed fund, the community chest or the Red Cross in order that others who are ill may receive care. How much more reasonable is a plan which substitutes for emotional appeal the practical benefits resulting from giving to a recognized charity!

# Information Cheerfully Given

EMANUEL GIDDINGS,  
M.D.

EVERYONE who has had any contact with hospitals is aware of the confusion, rush and strain associated with the information bureau. The employees in this department are under constant tension because of the numerous requests from anxious relatives who desire to learn the condition of the loved sick one. The inadequate stereotyped information too frequently given is the source of numerous complaints. Most of us have been irked by the seemingly impersonal replies offered to inquiries regarding the improvement or lack of improvement of a patient.

This problem is not localized, but in the manner of a centipede spreads itself out until it affects the hospital as a whole. The information clerk must call the ward and in so doing adds to the already overburdened telephone service and the redundant duties of the nurses.

For example, Mrs. Jones comes to the information bureau seeking information regarding Mr. Jones. Mr. Smith, the information clerk, calls the ward and Miss Black, the nurse, leaves whatever she is doing to answer the telephone.

"How is Patient Jones?" asks Mr. Smith. Miss Black has 40 or 50 patients, three of them named Jones. After determining which Jones is the patient in question, she goes down the ward, procures Mr. Jones' chart and reviews it to ascertain his condition. She then returns to the telephone and replies: "Condition is about the same." Mr. Smith transmits this information to Mrs. Jones.

"Well," says Mrs. Jones, "what do you mean by 'just the same'?" He was stricken suddenly and I do not know what the trouble is." Another call to the ward reveals Mr. Jones' case has been diagnosed as appendicitis and the natural question is "When do they intend to operate?"

Doctor Giddings is the medical superintendent, Kings County Hospital, Brooklyn, N. Y.



The information desk at the University of Chicago Clinics is presided over by two extremely busy but always courteous young men.

Again Mr. Smith calls Miss Black. She, through no fault of her own, is not cognizant of the future plans for the patient. Perhaps the procedure has not as yet been definitely decided and no note has been made on the chart. Miss Black realizes that Mrs. Jones is very anxious and calls the resident surgeon. After some time elapses, while the operator locates the surgeon, he responds and informs her that they have had a consultation but no decision has been made. She so informs Mr. Smith, who in turn transmits the information to Mrs. Jones.

In the interim, time has passed and Mrs. Jones, because of her anxiety, overestimates the length of her wait. In spite of this seemingly lengthy period, she now knows little more than she did when she came in. Be-

fore Mr. Smith finishes speaking with her, she becomes angry and proceeds to the administrator's office to register a complaint. There, more people are diverted from their work to repeat the same procedure, explain in more detail and pacify Mrs. Jones.

There have been at least five telephone calls regarding this one request. The nurse has been forced to neglect her nursing care to supply the information and the resident surgeon has twice been called from ministering to a sick patient in order to furnish professional advice.

Time and again, this and similar situations occur. There are four or five patients of the same name in the hospital and, in the pressure of business, the wrong information is unwittingly furnished.

The "Waterloo" of all information



clerks are the people who have not as yet mastered the English language, or those who are illiterate and cannot supply the correct spelling of a patient's name.

A hospital is severely criticized if, by chance, inaccurate or incomplete information is furnished. But can one really blame the division or an individual for this? In the majority of hospitals the informants are varied and the responsibility is not definitely designated. All administrators are striving for the efficient functioning of the hospital and the first step toward the solution of this particular problem is the fixing of responsibility; next comes the "condition sheet," and finally the follow-up.

The condition sheet is not new but, so far as I am aware, it is not in general use. The sheet is ideal in its simplicity. Entered on this sheet of paper are the patients' names, days of the week and symbols to describe the patients' conditions. The accompanying form gives an idea of the condition sheet in use.

The answer to the question of who is the most logical person to assume the responsibility for reporting the condition of the patient is obvious. It is the duty of the resident physician or surgeon, who may designate any one of his staff, depending on the arrangement in the individual hospital.

Next comes the condition sheet. The names of the patients are listed on the sheet by the nurse as they are admitted. Every morning when the doctor designated makes his rounds, he carries the condition sheet with him and marks the condition of each patient on the slip and also on the chart. As soon as morning rounds are terminated, the condition sheet is immediately brought by a messenger to the information bureau where the information contained thereon is transferred to the individual patient's card after which it is returned to the

#### Condition Sheet, Kings County Hospital

WARD.....	WEEK OF.....							
		Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Ned Jones		Crit	Crit	VS	VS	VS	VSI	Crit
John Jones		Crit	Crit	VS	VS	VS	VSI	C
Harry Brown		VSI	VSI	C	C	C	Dis.	
Joseph Smith		VS	VS	Crit	Crit	Died		
Fred Doe		VS	VS	Crit	Crit	VS	VSI	VSI

ward to be used again the following day. In order for the sheet to serve the purpose for which it is intended, it is necessary to set a time limit of 9:30 or 10 a.m. for all condition sheets to reach the information desk. Knowing the patients, it should not take more than fifteen to twenty minutes to write in all the conditions. Otherwise, there is a tendency toward carelessness and the value of the condition sheet is considerably lessened.

This leads to the follow-up. Like all activities, it is imperative in the beginning to concentrate on having the conditions completed accurately and promptly. A few words to the delinquent resident or house physician from the administrator are usually sufficient to correct any waywardness. Then, too, the staff members realize that by completing the condition sheet they will not be called during the day to furnish information and they are usually glad to cooperate; in fact, when the condition sheet was suggested at this hospital, it was they who urged its introduction.

We return to the information bureau after the condition sheet has been introduced. We again find our imaginary Mrs. Jones inquiring about the condition of her husband. Mr. Smith has the cards, filled in from the condition sheet in front of him. The typical patient's card is similar to the accompanying form.

"How is Mr. Jones?" inquires Mrs. Jones. Mr. Smith refers to his card. "We have two patients by the name of Jones on Ward A-1; what is your husband's first name?" asks Mr. Smith. "John" is the reply. "Mr. John Jones," Mr. Smith informs Mrs. Jones, "was admitted to the hospital on last Monday in a critical condition. He has been very sick but his condition today, while still serious, is somewhat improved. It is expected they will operate. I'm sorry but the operation has not as yet been definitely scheduled."

Mrs. Jones, reacting to the psychological effect, feels that the information clerk and the whole hospital are keenly interested in her husband because so much detailed information was available immediately. She thanks Mr. Smith and departs, feeling comforted.

While this method is not perfect and it would have to be adjusted to the individual hospital, it has certain definite advantages. A still more efficient procedure would be to repeat the activity on evening rounds. As the changes occur, such as discharges, transfers and deaths during the day and night, they are telephoned to the information office where the necessary revision is made at once.

The condition sheet has three definite advantages which tend to improve the furnishing of information regarding patients accurately and promptly. These are:

1. It offers a more intelligent type of information to inquiries rather than "good as can be expected" or "just the same."
2. It saves time for the information office, telephone operators, doctors, nurses and the superintendent's office.
3. It is an intelligent record of progress on the patient's card.

#### Patient's Card, Kings County Hospital

Name	John Jones	Address	St. Mark's Place	Ward	A-1
Age	35	Admitted	11/12/38		
Nearest Relative	Mrs. John	Address	Same		
11/12	Crit.				
11/13	Crit.				
11/14	V.S.				
11/15	V.S.I.				
11/16	V.S.I.-T.O.				

# Family Outlay for Hospital Care

MARGARET C. KLEM

THE irregular and unpredictable incidence of illness requiring hospitalization has led to the rapid growth of hospital care insurance. Some 2,500,000 persons in 60 communities in the United States are now protected by such insurance. Although this number is large, the great bulk of the self-supporting population still pays for hospital service on an individual basis and when prolonged hospitalization is necessary in a family of modest means, it becomes necessary to deplete savings or incur debt.

It is, accordingly, of special interest to examine preliminary data on hospital care expenses recently made available from the study of Consumer Purchases.<sup>1</sup> This study was conducted to collect significant and widely representative facts on how American families earn and spend their incomes. Included in the broad picture of outlay for family living were figures on expenditures for 15 main groups of goods and services, which were reported in some detail. These data throw considerable light on how much self-supporting native

white families<sup>2</sup> are spending in a year for the several items of medical care, including the services of physicians, dentists, nurses and hospitals.

Food, housing (including fuel, light and refrigeration) and clothing comprise those categories commonly taken to represent the basic essentials. An estimate of the percentage of family income remaining after these groups have been provided furnishes a rough measure of the economic well-being of the families studied. In the higher income classes the outlay for each of these categories includes elements of comfort, convenience or display as well as satisfaction of the prime needs inherent in each, but at the lower economic levels it is probable that expenditures for these groups of items provide little if anything above what current standards would class as actual essentials.

## Essentials Take All Income

For many families at the bottom of the economic scale expenditures for food and housing alone took as much as three-quarters of the annual income. At incomes below \$1000, village families spent about two-thirds of their income for the essentials of food, housing and clothing, while families living in small cities spent nearly three-fourths. In the metropolitan areas (New York and Chicago) expenditures for these three items accounted for more than 80 per cent of the income in families having from \$1000 to \$1500 while in families with incomes of less than \$1000 these expenditures exceeded the amount of the income. (Table 1.)

The average outlay for each of the main groups of items included in family living increased consistently with income, but the relative importance of some groups rose while that

<sup>2</sup>In four states in the Southeast a separate sample of Negro families was also studied. This paper deals only with native white families that received no form of relief during the survey year.

of others declined in the higher income classes. Among families living in metropolitan areas food absorbed more than one-half of the income when it was below \$1000, and less than one-third when it was between \$3000 and \$4000, while the proportion of the income spent for shelter declined from more than 44 per cent to about 20 per cent in these same income groups.

Only when the income was \$2000 or more were expenditures less than income. Families with lower incomes had expenditures in excess of income, with the consequent necessity of going into debt or drawing on the savings of previous years.

The part of total family income accounted for by medical care in general amounted to about 5 per cent of the total and showed no consistent tendency either to increase or decrease as income rose. When the percentage of family income expended for medical care is compared with the percentage expended for other items found in the family budget, it might seem at first glance that the families would have no difficulties in meeting these bills.

It was found that among metropolitan families, for example, a larger share of the family income went for recreation and tobacco than for medical care, regardless of the size of the income, and among families with incomes of \$2500 or more, a larger proportion was spent for the automobile than for medical care.

## Care Increases With Income

However, as previous studies in this field have pointed out, the average expenditures of families for medical care have no meaning when one is considering the ability of a particular family to meet these costs, because it is only by chance that a family may be called upon to pay what corresponds to the average medical charge.

The average amount spent for medical care increased regularly with income; among village families, for example, with incomes of from \$500

Miss Klem is on the staff of the Bureau of Home Economics, U. S. Department of Agriculture, on leave of absence from the Social Security Board.

<sup>1</sup>The Study of Consumer Purchases was conducted jointly by the Bureau of Labor Statistics, U. S. Department of Labor, and the Bureau of Home Economics, U. S. Department of Agriculture, as a W.P.A. project. The National Resources Committee and the Central Statistical Board acted as cooperating agencies in formulating plans and providing technical supervision. Data contained in this article have been derived from preliminary tabulations. Those for metropolitan communities are for New York and Chicago in which the Bureau of Labor Statistics conducted the investigation; those for medium sized cities represent communities in the East Central region studied by the Bureau of Labor Statistics; those for small cities, villages and farms represent communities studied by the Bureau of Home Economics. Complete reports will be issued by these bureaus on the results of the study in their respective jurisdictions. In combining communities of the same degree of urbanization in different parts of the country to obtain a broader base for averages and percentages, equal weight was given communities in each region.

Table 1—Percentage of Total Family Income or Expenditure Used for Specified Items by Native White Families With Specified Annual Family Incomes, 1935-36

Items of Family Living	Metropolitan Communities (Percentage of Total Family Income)						Small Cities (% of Total Expenditures)	Villages <sup>3</sup>
	\$500-999	\$1000-1499	\$1500-1999	\$2000-2499	\$2500-2999	\$3000-3999		
Food.....	54.4	42.0	36.5	34.0	30.9	28.1	28.6	30.9
Clothing.....	8.0	7.8	8.4	9.0	9.7	10.3	11.1	9.6
Housing <sup>1</sup> .....	44.5	31.2	27.6	24.5	22.5	19.6	12.0	10.1
Household Operations.....	4.0	3.6	3.8	4.6	4.7	5.6	9.6	10.0
House Furnishings.....	1.8	2.4	2.7	2.6	2.8	2.5	5.2	5.0
Automobile.....	0.5	2.0	3.8	4.3	6.1	5.9	12.6	14.6
Other Transportation.....	3.5	2.9	2.4	2.2	2.2	2.0	0.7	0.4
Personal Care.....	2.7	2.1	2.1	2.1	2.1	2.1	2.2	2.4
MEDICAL CARE.....	3.5	4.5	4.6	4.7	4.4	4.4	5.2	5.7
Recreation.....	2.0	2.2	2.6	3.0	3.1	3.4	4.2	3.6
Tobacco.....	2.5	2.6	2.4	2.2	2.0	1.8	1.6	1.6
Reading.....	1.6	1.2	1.2	1.1	1.0	1.0	1.1	1.1
Education.....	1.2	0.2	0.4	0.5	0.6	0.8	1.2	0.8
Gifts.....	1.6	1.6	2.4	2.8	3.4	4.5	4.3	3.6
Other.....	0.2	0.2	0.4	0.5	0.4	0.3	0.4	0.6
Total <sup>2</sup> .....	132.0	106.5	101.3	98.1	95.9	92.3	100.0	100.0

<sup>1</sup>Including fuel, light and refrigeration.

<sup>2</sup>The difference between the average annual money income and the average expense (the difference between the total and 100 per cent) is approximately equal to the net change in family assets and liabilities for families in metropolitan communities.

<sup>3</sup>Since no families with incomes of from \$4000 to \$9999 were included in the consumption analysis for villages but were included for small cities, the percentage distributions of expenditures for the two types of communities are not strictly comparable, particularly for those categories whose relative importance increases or decreases with income. It is probable, however, that these distributions would resemble each other even more closely if they were based on the same income range.

Table 2—Average Annual Expenditures per Family for Specified Items of Medical Care, by Income, in Communities of Selected Degrees of Urbanization, 1935-36

Locality and Income	Average Expenditures of All Families for Specified Service							
	All Medical Care	Physician	Dentist	Oculist, Optician and Eye Glasses	Other Specialist	Hospital	Private Nursing	Drugs and Medicines
<b>Metropolitan Communities</b>								
\$ 500- \$ 749.....	\$ 18.10	\$ 7.30	\$ 2.15	\$ .15	\$ .20	\$ 1.05	.....	\$ 5.45
750- 999.....	32.35	11.50	8.00	.70	2.05	2.55	.....	5.15
1,250- 1,499.....	57.55	16.15	11.10	2.75	4.50	12.35	\$ 1.10	8.55
2,000- 2,499.....	101.58	32.93	21.55	4.68	6.50	15.42	2.15	14.03
3,000- 3,999.....	143.33	34.25	43.83	7.35	15.50	13.57	5.20	17.13
<b>Small Cities</b>								
\$ 500- \$ 749.....	38.98	12.83	3.38	2.93	4.91	4.05	.17	6.50
750- 999.....	52.52	17.64	4.73	2.61	4.18	7.86	.99	8.75
1,250- 1,499.....	68.88	20.78	10.52	3.85	5.10	6.91	1.03	10.08
2,000- 2,499.....	96.40	23.12	16.50	6.29	8.69	10.23	2.00	13.73
3,000- 3,999.....	137.82	30.93	24.43	7.60	12.44	14.52	7.82	15.81
<b>Villages</b>								
\$ 500- \$ 749.....	35.65	11.87	3.45	1.97	3.02	4.09	.38	7.55
750- 999.....	39.33	13.73	4.41	2.31	2.06	5.32	1.19	6.16
1,250- 1,499.....	58.45	17.50	8.35	3.36	5.39	6.90	1.20	8.18
2,000- 2,499.....	87.28	21.13	14.11	5.32	8.30	10.85	3.42	9.94
3,000- 3,999.....	145.89	31.19	19.87	6.67	16.96	22.49	7.71	16.47

Table 3—Percentage of Native White Families Having Expenditures During the Year for Hospital Room or Bed, by Income, in Communities of Selected Degree of Urbanization, 1935-36

Income Class	Large Cities	Medium Sized Cities	Small Cities	Villages	Farm Counties
\$ 500- \$ 999.....	7	4	10	7	5
1,000- 1,499.....	12	12	13	11	6
1,500- 1,999.....	14	15	13	14	10
2,000- 2,499.....	17	16	14	15	9
2,500- 2,999.....	14	13	17	19	17
3,000- 3,999.....	16	11	18	22	19

Table 4—Average Expenditures per Family for Hospital Care Based on Native White Families Having Such Expenditures, by Income, in Various Communities, 1935-36

Income Class	Large Cities	Small Cities	Villages
\$ 500- \$ 749... ..	\$ 16	\$ 45	\$ 57
750- 999... ..	39	72	92
1,250- 1,499... ..	128	53	65
2,000- 2,499... ..	90	71	72
3,000- 3,999... ..	84	79	106



to \$750 the average cost of medical care was about \$36; in the income range from \$1250 to \$1500 the family spent, on the average, \$58, and families with incomes of from \$3000 to \$4000 spent approximately \$146. (Table 2.)

The same increase in average expenditures from the low to the high income groups is true in communities of all sizes. The average expenditures for medical care increased about three-fold in metropolitan areas for families with incomes of from \$3000 to \$4000 as contrasted with families with incomes of from \$1000 to \$1500. Increase in medium sized cities between these two income groups was from \$46 to \$109 and approximately the same increase occurred among families living on farms.

The average expenditure of \$36 among village families with incomes of from \$500 to \$750 is obtained by averaging such varying amounts as expenditures of less than \$10 reported by 38 per cent of the families and expenditures of \$100 or more reported by 7 per cent of the families. The \$130 average expenditure of village families having incomes from \$3000 to \$4000 represents expenditures of less than \$40 made by almost one-half of the families and expenditures of \$200 or more made by less than one-tenth of the families.

The question, "What is the average expenditure of families for hospital care?" is also answered in table 2. No separate tabulations have been made of the total outlay by families that utilized hospital services. Accordingly, the proportion of hospital expense to total medical care expense is lower than was actually the case for the families that had hospital bills to pay, because the medical care outlay by the majority of families included no hospital expense.

When data for all small cities studied by the Bureau of Home Economics are combined they show that hospital expense varied from 10 to 16 per cent of total medical care in the several income classes. In the villages these variations were from 12 to 17 per cent. In neither group of communities nor in Chicago and New York was there any consistent tendency toward either increase or decrease in the proportion of total medical care expenditures accounted for by hospital service.

In assessing the place of hospital costs in the total medical care bill, however, and in considering the ability of families in the various income groups to meet this expense, the first point to consider is the proportion of families in different income groups that incurred expenditures for hospital care during the period covered by the record of family expenditures (table 3). The fact that hospital expense was incurred by fewer than one family in five among most income groups included in the study does not necessarily indicate the ratio of families using hospital facilities in the population as a whole. Among those studied a few families who obtained hospital care without direct outlay were not counted.

Generally speaking, the proportion of farm families having hospital expense was slightly lower than it was for corresponding income groups in the urban communities, and in the lower portion of the income scale it was smaller in villages than in small cities. The percentage of families having hospital expense in New York and Chicago was not consistently higher than was found in the smaller cities. Automobiles and good roads have doubtless contributed to minimizing the differences among communities of different sizes in the

relative frequency with which hospital care is purchased.

The average amounts spent during the year for hospital care were comparatively small when the aggregates were distributed among all families in the group. On this basis such averages were generally less than \$15 and even in New York and Chicago they reached \$20 and more only in the high income classes. There was an irregular upward trend with income in these averages, but the amount of the increase was very moderate and was mainly a reflection of the increased proportion of families spending in this way.

The burden of hospital expenses to the families that incurred such outlay was much greater than the amounts reflected in these all-family averages. Among families in the small cities and villages studied by the Bureau of Home Economics, those that incurred hospital expense reported amounts that averaged less than \$75 in most income classes (table 4). There was even greater irregularity, however, from one income class to another in these averages than in those based on all families.

In most groups of communities the upward trend with income in the amount spent was slight and averages in some low income groups were almost as great as any reported at the upper end of the income scale. There were thus marked differences among these families in the percentage of income used to defray hospital expenses.

The relative unevenness of the burden is shown even more clearly in the distribution of families by the amounts spent for hospital room or bed. Table 5 shows, for a selected community studied by the Bureau

(Continued on page 51)

**Table 5—Percentage Distribution of Native White Families Living in North Central Small Cities With Expenditures for Hospital Care, by Income and Amount of Expenditures for Hospital Care, 1935-36**

Income	Families Having Expenditures	Percentage of Families Having Specified Expenditures for Hospital Room or Bed									
		Total	Under \$10	\$10-19	\$20-29	\$30-39	\$40-59	\$60-99	\$100-149	\$150-249	\$250 and Over
\$250 — \$999.....	49	100	17	12	12	14	17	16	4	6	2
1,000 — 1,499.....	98	100	11	18	11	20	16	11	8	3	2
1,500 — 1,999.....	86	100	13	9	9	9	29	12	9	5	5
2,000 — 2,499.....	49	100	10	15	8	8	14	17	14	10	4
2,500 — 2,999.....	31	100	6	10	6	13	23	20	6	6	10
3,000 — 3,999.....	32	100	3	9	6	3	35	19	16	6	3

# Neither Wind Nor Rain

**N**EITHER wind nor rain, hurricane nor flood, has interrupted the service that the Cooley Dickinson Hospital of Northampton, Mass., has rendered for fifty-four years. Since 1885 its doors have stood open; not the same doors, to be sure, for the original little gray stucco building has been relegated to the rear where it now houses the employees. In its place is a comfortable, spacious building with wide, airy corridors, erected in 1908 but since

RAYMOND P. SLOAN

hospital conscious but its enthusiasm has spread to many smaller towns that dot the neighboring hills.

If evidence of this staunch support were needed, we have only to turn back a few months to the fall of 1938 when hurricanes and floods ravaged New England and parts of New York State. During those dark hours when the problems of caring for pa-

tients and victims of the storm became acute, the entire town rallied to the aid of the hospital. Where help was sought, it was given gladly, freely. The hospital serves and is served.

There have been other occasions, too, when disaster threatened. Despite its location on high ground far removed from the river, a serious flood in 1927 wrought great damage to that area and, again, in 1936 high water threatened the service of the



completely modernized with new wings added and space provided for future expansion.

The years have brought with them, too, the realization of an early dream, a new residence for nurses. The result is a well equipped, modern hospital of about 150 beds that serves Hampshire County and a radius of 40 miles.

Surely such service through the years could not help but engrave itself on the hearts and minds of the people! It has. You find in Northampton community support at its best. Not only is the city itself hos-

Looking down on a hospital looked up to by an entire county. This is the 150 bed plant of the Cooley Dickinson Hospital, Northampton, Mass. In this city community support for the hospital reaches a high pitch because the hospital renders good service in times of disaster and calm.

Neither hurricane nor flood can completely paralyze this operating room. When even emergency lights failed following prolonged flood, auto headlights were used to permit essential surgery to go on. In the same flood the sterilizing room was transformed into the kitchen and autoclaves were employed to cook the chicken.







The baby lying on the table in the illustration finds himself in a room that is well lighted by natural sunlight as well as by artificial means.

Below: "Expectant father, help your wife keep fit," says a poster above this young man's head. But he is learning more than that at Cooley Dickinson Hospital. A nurse gives the father as well as the new mother lessons in infant care with a doll on which to do the practicing. Diaper changing is only the first step. The doll wears real baby dresses. Formula preparation is a lesson that it is valuable for both parents to know.

hospital by cutting off power, light and gas. Yet its doors remained open and the work of caring for the sick and suffering went on.

Emergency work at Northampton is not confined exclusively to the accident ward. It has been carried on at one time or another in every part of the hospital, even to the extent of transforming the sterilizing room into a kitchen and cooking chicken in the autoclave. There are those on the staff who will tell you that it was the best chicken they ever tasted.

There is nothing about these emergencies peculiar to Cooley Dickinson. The difficulties of carrying on without power, light or gas are likely to face any hospital administrator almost any time. What thought, if any, has been given to meeting these problems?

No one is better justified in raising this question than Miriam Curtis, superintendent of Cooley Dickinson, who speaks from experience. "The time to make plans and prepare is before the emergency arises," she states emphatically. "It is wise to be always mindful of facilities immediately available in the community. Time does not permit sending any distance for help and often the community is completely isolated."

When storm signals tell of impending dangers, the first thought is the operating room. Emergency storage battery outfits are indispensable, of course. But what happens when the hospital is without light for thirty-six hours? This was the situation in Northampton last September, despite the assurance of the head of the local lighting company that the building would be the first

to have its service resumed. Here is how Miss Curtis and her staff met the situation.

With the cooperation of automobile dealers and shops in the town, a number of automobile batteries and headlights were procured. These were adjusted around the operating room so as to permit essential work to go on. Only emergency operations were scheduled. All others





were postponed. Thus, with the help of the townspeople, the problem was met.

As those superintendents who have had experience will attest, a tie-up in the laundry can inflict the greatest problem of all. It is possible to restrict changes of linen to a minimum, to be sure, and small pieces, including diapers, can be washed by hand. Yet as the hours pass and supplies run low, the shortage becomes acute. At such times, too, there is no possible help from outside laundries, because their facilities are similarly crippled. Miss Curtis was prepared to call for a tractor or a generator which might be backed to the window of the laundry and a belt inserted to the washing machine. Entirely feasible, provided the washing machine is equipped with a pulley.

The situation was not as grave in Northampton during the recent hurricane as in 1936 when flood waters threatened to cripple the service. Then there was no gas for cooking. So quite unexpectedly, the sterilizing room became the kitchen. Cereal was prepared successfully in the instrument sterilizer, which served as a double boiler. Anything that could be steamed was put in the dressing sterilizer and, as already indicated, much enthusiasm was aroused over the palatability of the chicken prepared in the autoclave. A charcoal burner in the yard outside was used to boil coffee.

The question is, how much of an investment should any hospital have tied up in equipment to meet emergencies that may seldom, if ever, occur? On the other hand, protection must be provided those lives entrusted to its care. The desirability of having a generating plant of its own is obvious. Yet again, the factor of expense must be considered. Coal as a fuel has its advantages, Cooley Dickinson has discovered; or, at least, a coal burning generator to forestall any lapses in the electric service.

It is apparent that each institution must study its own resources and size up its own situation. The important thing is that this be done in advance and with the benefit of voluntary aid that has received some advance preparation.

It is not only when emergency arises that the town of Northampton comes to the support of its hospital. Throughout the year a strong women's auxiliary of between 400 and 500 members carries on many projects in its behalf. Two representatives from each church, irrespective of denomination or creed, comprise a board of directors totaling some 60 women. These meet at the hospital every other month. The group as a whole assembles three times each year, when Miss Curtis tells them of interesting developments of the hospital and some outside speaker talks about hospital work generally.

If only it were possible for every hospital to have someone with a pleasing personality meet visitors as they enter and furnish them with whatever information or aid they may require—a hostess, for want of a better title. How many times has this thought been expressed?

The need is fulfilled quite satisfactorily at Cooley Dickinson by the hostess committee of the Dickinson Hospital Aid Association. One



Happy patient at Cooley Dickinson.

woman from the committee spends an hour every day in the hospital during visiting hours greeting those who enter, answering questions and extending little courtesies to make the stranger feel more at home. It upholds the reputation of the hospital to have representative women of the community in attendance. They, in turn, benefit through this first-hand acquaintance with hospital life.

Another group of women comprises what is known as the flower

committee. Throughout most of the year, but particularly when the gardens are in bloom, these women keep the hospital supplied with flowers, which they themselves arrange. They have their own flower room equipped with vases and holders and different towns take turns in getting the flowers to the hospital and in making artistic arrangements. They also help decorate for commencement and other special events.

The sewing committee, an important function of hospital auxiliaries generally, is particularly active in Northampton, meeting every other week and sometimes every week. The members have discontinued making gauze dressings because it has been found cheaper to buy them, but they do mending and work with the seamstress who is employed full time under the supervision of the housekeeper.

Most interesting, perhaps, of all the projects in which the women of the community participate is the social and recreational committee for the school of nursing. This is especially popular, the work being carried on by various subcommittees. Twice a month teas are held by the nurses with two hostesses in attendance. Preceding these affairs, instruction in contract bridge is sometimes provided.

Through arrangements made with Smith College, a glee club is conducted under the leadership of someone from the college; also classes in ballroom and folk dancing. The glee club performs at hospital functions and, at Christmas time, even serenades the homes of trustees, doctors and members of the women's auxiliary.

In summer, instruction in swimming is provided at the park pool. This is also the picnic season, two picnics taking place each month. The women furnish transportation for the nurses and take great delight in making the spreads as appetizing as possible.

There are sewing classes for the nurses, too, and reading groups. Those interested in the latter meet at regular intervals and read aloud from plays. This is especially good training for the girls. The Smith College authorities cooperate in these activities by supplying students who

desire the experience or teachers who are willing to assume such outside responsibilities.

A short time ago a dance was held by the girls, sponsored by the ladies' group. The difficulty in Northampton, as elsewhere, lies in getting a sufficient number of men. It was decided, therefore, to import 35 students from a near-by men's college, the ladies providing the transportation. At this party, the nurses were not permitted to invite their own guests. As each man entered, he was given a card on which was written the name of a motion picture actress. The girl holding the corresponding card was his partner. Other games, too, were provided to get everyone together. Under the circumstances, the evening could hardly help being a happy one. At Christmas time, too, the students are entertained by the committee, prizes for various games taking the place of gifts.

This social and recreational committee is not to be confused with the regular nursing committee. Here we find what appears to be an ideal setup for such a committee. The chairman, a woman, is a member of the hospital board. Those serving with her, however, are not necessarily board members. Each is selected carefully for his or her ability to contribute something from a professional background to the subject of nursing. There are an educator, a public health nurse, a doctor on the staff, the head of the nursing school and, of course, the hospital superintendent.

While on the subject of nursing, it is interesting to add that the hospital is fortunate in having the co-operation of Smith College in its educational program. The college provides instruction in chemistry, bacteriology and psychology, supplying teachers and granting the use of its laboratories.

Notwithstanding the great amount of support that the hospital already receives from the community, there is in process of formation at this time a public relations committee. Surely here is a hospital that is cultivating the good will, interest and support of its community. It is likely that this group will work closely with civic bodies and assume responsibility for the projects which

the women's auxiliary, as active as it is, cannot hope to cover.

In the past, the Rotary, Kiwanis and other organizations have held dinners at the hospital, following which they have been taken on tours of inspection. Women's groups, too, have been similarly entertained. Development of these and other public relations contacts will furnish opportunity aplenty for this committee.

If it is so, and who will deny the truth of the statement, that a strong group of auxiliary workers generally means a strong hospital, that is, one meeting the public health needs of the community efficiently, there is substantiation for the type of service which Cooley Dickinson has been rendering for fifty-four years and which neither wind nor rain, hurricane nor flood, can even interrupt.

## Family Outlay for Hospital Care

(Continued from page 47)

of Home Economics, the percentage of families in each income class that reported expenditures of specified amounts. For example, 55 per cent of the families with incomes under \$1000 that had hospital expense reported an outlay amounting to less than \$40; 12 per cent had expenditures in excess of \$100, while 8 per cent spent more than \$150. For the 12 per cent spending more than \$100 and belonging to an economic group whose average income was only \$694, such an outlay for hospital care must have involved serious problems of providing for all family needs. At the upper end of the income scale, on the other hand, among families with incomes of from \$4000 to \$9999 the one-third of those with hospital expense that had bills in excess of \$100 were probably not as heavily burdened by this outlay as were those in the lower income group whose hospital bills were relatively small.

In each community studied the same results were obtained, namely, in each income class having a large enough number of families to provide significant distributions, there is generally to be found a fairly substantial percentage of families spending more than \$100, and in the majority of cases a few families spending \$250 or more.

Differences in communities surveyed and in basis of income classification between the present study and that conducted by the Committee on the Costs of Medical Care<sup>3</sup>

prevent any close comparison of results for the two studies. It is, nevertheless, interesting to note that results of the earlier investigation revealed an over-all ratio of about one family in five that had recourse to hospital facilities during a twelve month period. This ratio, which is based on all families receiving care, regardless of whether free or pay, is probably somewhat higher than that which would appear in the present study if all income groups and all communities were combined, but the difference would not be striking.

Substantially the same distributions of families with respect to amount of hospital expense that are found in this study were presented in the report by that committee.

The rapid extension of hospital care insurance plans reflects the desire of families for protection against unpredictable hospital charges. But these plans as now set up have only limited application since those who have sought membership have been largely members of families with incomes of \$2000 or more, the majority of members probably belonging to the income class of from \$2000 to \$3000. Even if the total population in this income class were enrolled in hospital care insurance plans, only 11.5 per cent of the entire population would be covered. Since four families out of five in the United States have annual incomes under \$2000 a year, it seems likely that some other or less expensive plan will have to be evolved to meet the costs not only of hospitalization but of other medical care services for these low income families.

<sup>3</sup>Falk, I. S., Klem, M. C. and Sinai, N.: The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families, University of Chicago Press, 1933.



# Hospital Day in

HELEN N. RICE, R.N.

AN EXTENSIVE publicity campaign, supplemented by careful planning for weeks beforehand, preceded the observance of National Hospital Day at the Paradise Valley Sanitarium and Hospital, National City, Calif., last year. The program won for the hospital the American Hospital Association's award for the best program in cities of less than 15,000 and the publicity award in the same class. The previous year Paradise Valley Sanitarium and Hospital had received the association's award for the educational value of its exhibit.

Publicity for National Hospital Day centered about health education and disease prevention and was aimed to demonstrate the essential place of the hospital in this educational program. Scores of devices were used to carry this message to more people than ever before. Every worker in the institution from the medical director down was dating every event of importance to May 12. The very air vibrated with the spirit of Hospital Day.

This enthusiasm spread to the chief executive of the state, for Governor Frank F. Merriam had promised to come from Sacramento to be a guest of honor. Governor Rudolfo Sanchez Taboada of Baja, Calif., across the Mexican border, also accepted the invitation to join in the celebration. As a gesture of good will it was planned to have the two governors meet and clasp hands across the border and then, accompanied by their staffs, arrive at the hospital in time for luncheon.

Before portraying the events of the day, let us visit the hospital grounds in order to visualize the setting of the day's program in which between 8000 and 9000 people had a part.

As one entered the grounds through the archway the first object

that came into view was the wreck of a car, bearing a sign "Wreck-ord of Alcohol." It was disclosed that the wreck had occurred early the previous morning and the car's two occupants, under the influence of alcohol, were instantly killed. Just back of this thought-provoking display was demonstrated with motion pictures the cure for "auto intoxication, 1938 variety," under the auspices of the Sweetwater High School traffic

school and the National City police department.

Beyond this was a palm covered booth marked "First Aid," in which at intervals throughout the day were given demonstrations of treatment of hemorrhage, artificial respiration to resuscitate a drowning person and first aid in fainting. An exhibit of x-ray films of fractures of various types made impressive the lesson illustrated by posters at one booth.



Above, right: "Mrs. Everwell" and "Mrs. Neverwell" each looks the part that she portrays at the dietetic booth. Their choice of diets tells the story. Below: One of five scenes depicting the advancement of medical science. Surgeons in pre-Lister days operate dressed in Prince Alberts.



# Paradise Valley

Director, School of Nursing  
Paradise Valley Sanitarium and Hospital

"Mrs. Everwell" and "Mrs. Neverwell" drew interested groups to the dietetic booth. Their respective medicine cupboards provided a valuable lesson and the discussion of Jimmie's health was full of suggestions on good health habits and provided a touch of humor. As the two women sat at the dinner table, their choice of diet told forcefully why one was ever well and the other, never well.

In the next booth, under the aus-

pices of the San Diego County Medical Society, was portrayed the part that animal experimentation plays in the diagnosis and treatment of disease. A little farther on, under the shade of a big tree, guests were provided with a refreshing drink.

The exhibits which probably attracted the most attention were five scenes portrayed realistically in the booths on the veranda of the nurses' home. The theme was "Advancement of

Medical Science Since the Day of Florence Nightingale."

At the far end of the building, near the hospital, stood an old war time ambulance, with its leather springs, canvas enclosure and team of horses. In contrast was a modern ambulance with all its fine appointments and its attendants in white uniforms.

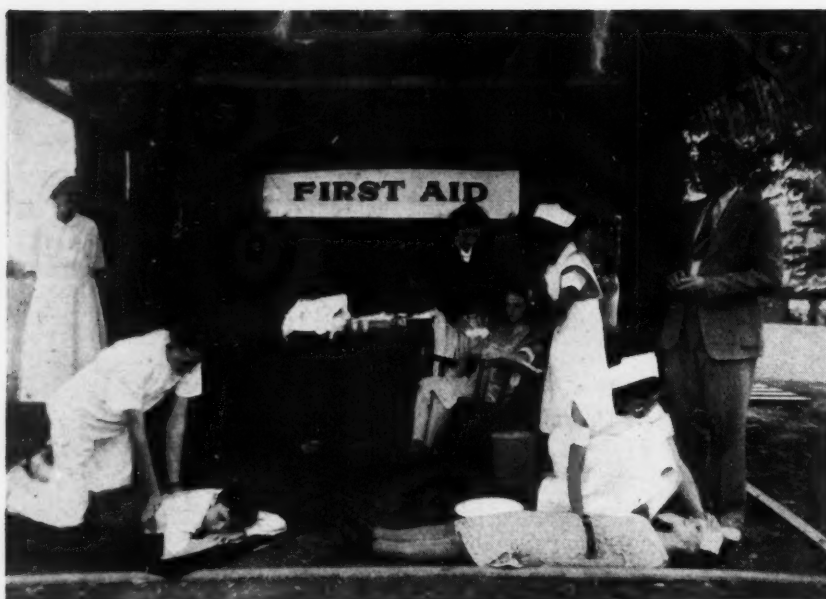
The next display was a contrast in operating rooms of the eighteenth and twentieth centuries. In the first booth were surgeons of pre-Lister days, dressed in their Prince Alberts with their sleeves turned back to save their coats. Anesthesia was then unknown and in the demonstration the patient was held by strong men while a leg apparently was being amputated. In the adjoining booth was a typical modern surgery. The patient apparently was receiving a gas anesthetic and an abdominal operation was in progress. As groups of visitors came the nurse in charge gave through the microphone an historical sketch of the development of surgical technic.

The "Dark Period of Nursing" was depicted in the next booth. A salvage shop furnished equipment. The bed, wide and enclosed with curtains to give privacy, was characteristic of its period, with five patients suffering from different types of ailments, in one bed. This scene was followed by the "Dawn" with Florence Nightingale in the Crimea, ministering to the wounded soldiers.

In a near-by booth a contrasting setting introduced the modern hospital ward, in which was demonstrated the use of modern equipment, such as the oxygen tent, Connell suction, intravenous infusion and the like. The ward was supervised by an alert, efficient nurse of today. Visitors were given a glimpse of the methods of identifying infants by



Above, left: "Wreck-ord of Alcohol," a thought provoking display that greeted visitors entering the sanitarium gates. Below: This scene is typical of the "Dark Period of Nursing," complete with five patients in one bed, curtained for "privacy," and "Sairey Gamp" complacently sipping her tea.



Above, left: At intervals during the day realistic first aid demonstrations were given. Right: The old-time country doctor on horseback led the parade that was the grand finale on the program.



name necklace, footprints of the infant and thumbprints of the mother on the birth certificate.

In the assembly hall throughout the morning ever changing groups of school children were interested in the motion pictures and lectures on the evils of nicotine and other habit forming drugs. Tours of the lower floors of the hospital and sanitarium also were arranged for visitors. Each teacher received a complimentary copy of "Plain Facts" and "Science Speaks," two new books on liquor, tobacco and narcotics.

The morning hours were planned especially for pupils from the schools. The plan was for high school pupils to arrive somewhat later and be on the grounds when Governor Merriam would arrive at noon. Many visitors came in the morning and spent the day on the hospital grounds. Long before 2 p.m. when the official program was scheduled, the temporary seats provided were filled and small boys were perched like birds on the big branches of the rubber tree in the foreground. The Sweetwater High School band in their bright red, gold-trimmed uniforms added a pleasing touch of color to the scene.

The arrival of the official party had been delayed by stops along the way and this shortened the luncheon hour and made it necessary to eliminate the addresses planned, in order to have time for a radio broadcast. Included in the official party, besides Governor Merriam and Governor

Taboada and their official escorts, were officers of the Army, the Navy and the Marine Corps and civic officials of National City and near-by communities. Proceedings were broadcast locally from 2 to 2:30 p.m. From 2:30 to 3 p.m., the program was broadcast on a hook-up with 25 Pacific Coast stations from Mexico to British Columbia.

The speaker's platform had been set up in the driveway in front of the main entrance. The Stars and Stripes floated lazily from a standard at one side of the platform and the Mexican flag from the other side. A student nurse, garbed to represent the statue of Florence Nightingale at Johns Hopkins Hospital, posed at one side of the platform. A microphone and loud-speakers made it possible for everyone to hear the entire program with ease.

The medical director of Paradise Valley Sanitarium and Hospital introduced Admiral Sinclair Gannon, who served as master of ceremonies and introduced the speakers, Governor Merriam, Governor Taboada and Dr. Percy T. Magan, president of the College of Medical Evangelists of Loma Linda and Los Angeles.

Just as the applause following the last speech died away, the sound of

a horse's hoofs was heard on the pavement and down the driveway came the old-time country doctor on horseback, carrying his equipment in his saddle bag. A few paces behind him came the old-fashioned phaeton conveying Miss Nightingale to the scene. With a clatter the old Scutari ambulance passed by, carrying a load of wounded soldiers. These were unloaded at the barracks hospital under Miss Nightingale's direction.

A more remarkable event followed. The audience was privileged to hear a reproduction of the actual voice of Miss Nightingale, obtained from a wax record made in London in 1890 and only recently discovered in the archives of the Edison Bell Record Company, London.

At the conclusion of the program Governor Merriam and Governor Taboada planted an evergreen tree in memory of Miss Nightingale. This tree is to be lighted during each holiday season. For the remainder of the afternoon visitors toured the buildings and revisited booths. Throughout the day movie cameras were busy making a record of the event and a fine reel of pictures is the result.

An evening program was planned for those employed or unable to come during the day. By 7 o'clock an appreciative audience had assembled. The Florence Nightingale "statue" again graced the platform and four speakers brought inspirational messages. Booths remained open so that the evening visitors could view the exhibits.



# Asepsis in the Operating Room



**I**MPORTANT as it is to have sterile goods delivered to the operating room, it is no less important to maintain sterility during the operation. To this end it is necessary to consider the architecture of the room itself, for under certain conditions of design it is almost impossible properly to protect the patient.

It is obvious, for example, that if a door directly connects a corridor and the operating room, the door should be kept closed during the operation. Nevertheless, there is plenty of experience to indicate that if the room is high above the street and the windows are properly screened, there is no danger in opening a window for ventilation, provided an excessive current of air is not entering and the opening is high above the floor. It is best, however, to cover the window screen with gauze, or one of the pollen screens may be used to advantage.

It may be important to remind nurses that all unnecessary items should be removed from an operat-

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**T. B. MAGATH, M.D.**

**Instrument table with sterile canopy, ready for major operation.**

ing room. Extra stools, shelves, bric-a-brac and apparatus should be taken to some other place in the hospital. Ledges that catch dust should be eliminated. It ought to be unnecessary to say that operating rooms should be "housewifely" clean. The walls should be wiped down with a wet cloth daily and all physical structures sponged over every day. This reduces dust. If a chlorine compound is added to the wash water it will do no harm.

Unfortunately, it is still necessary to call attention to the fact that all nonessential going to and from the room should be avoided and that visitors should be limited to those who can be easily seated in the gallery, the entrance to which should be by a door directly from the corridor and not from the floor of the room. The visitors should be thoroughly masked and their upper garments covered with clean gowns or white

coats. It would be advantageous to have a glass partition separating the gallery from the room.

No one should be permitted on the floor except the operating team and this should be reduced to as few persons as possible, in general the surgeon, his assistants (not more than two), the anesthetist, one or two sterile nurses and a nonsterile nurse. The nonsterile nurse should be the only person permitted to leave the room during the operation and the movements of others should be restricted to the region immediately surrounding the operating table. There is no need or desire for members of the team, except the instrument table nurse and the nonsterile nurse, to leave their positions. If this practice is followed it will add to the efficiency of the team and will lessen the motion of currents of air in the room; also, it will avoid the possibility of contaminating personnel and materials.

The clothing to be worn in the room is significant in regard to maintaining sterility. It is best that the team enter the room after having scrubbed up and the members of the



team should wear clean caps, which completely cover the hair, and sterile masks.

Many types of masks and caps have been designed but they must be made according to certain specifications to be considered acceptable:

1. Masks should cover the hair, ears, nose and mouth.
2. They should be sterile when put on.
3. They should be fitted with a piece of flexible metal, by means of which the mask can be made to fit around the nose and to offer ventilation so that spectacles will not become steamed over.
4. They should be tied beneath the chin.
5. They should be made of at least two thicknesses of cloth (fairly closely woven material should be used; a fine grade of French voile is excellent) and reenforced by at least four, preferably six layers, over the nose and mouth.
6. They should be comfortable.

The gowns, previously sterilized, should be donned in the operating room by the members of the team. Sleeves of the gowns should be long and the sterile (autoclaved) gloves should be put on so that the cuff of the glove comes up over the lower part of the sleeve of the gown.

The question of sterility of the air of the room has received much attention. It is known that agar plates exposed in a room will yield some colonies of bacteria in a given time and that the number will vary roughly with the number of people in the room and with the amount of commotion. An unusual bacterial flora may be observed after a dust storm. Fortunately, however, the proof that such bacteria are pathogenic has not been forthcoming and it must be assumed that only a small number actually are pathogenic. If this were not so, postoperative infections would be far more common than they are now.

It has long been known that bacteria tend to settle to the floor and since most, if not all, human pathogens in the air of the operating room come from the noses and mouths of persons in the room it is evident that air currents that keep the bacteria in the air above the level of the table should be avoided. For this reason

the floor may be kept damp to advantage for then the falling bacteria are trapped by the moisture on the floor and remain there.

This fact indicates the danger of using various air conditioners to circulate air in operating rooms. Unless the system is one by which the air is bacterially filtered before being returned to the room, such circulating machines should be considered open to grave question. The ideal conditioner should take the air from the level of the ceiling, bacterially filter it and return it at the level of the baseboard but there should always be a positive pressure in the room.

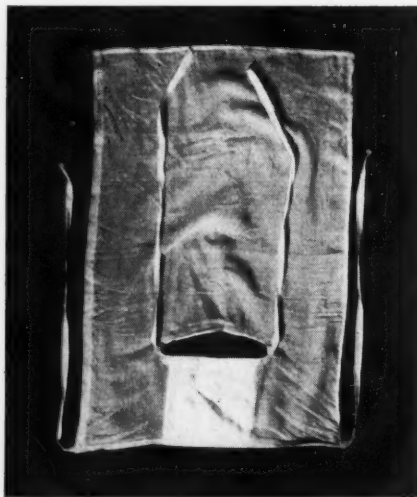
Devices have been introduced recently for the purpose of sterilizing the air of the room. This is accomplished by the use of certain ultraviolet rays. At present, evidence indicates that the time necessary to kill bacteria at any reasonable distance from the tube is too great to offer any material protection to the patient. Furthermore, any substance that intervenes between the source of the rays and the bacteria, such as gauze, rubber, glass, epithelial scales, serum, water or saliva, will protect the bacteria. Moreover, protection is offered by a shadow cast by any opaque material, as well as by oil or

grease on the glass tube from which the rays are emitted.

Since the most dangerous air-borne bacteria come from the faces of the members of the operating team, the very positions of the members of the team around the patient make it doubtful if such apparatus can offer much, or any, real protection. The device of slipping a piece of cellophane into the gauze in the mask is probably much more effective and just as comfortable as the mask, headgear and gown necessary to protect a member of the operating force against the ultraviolet light itself.

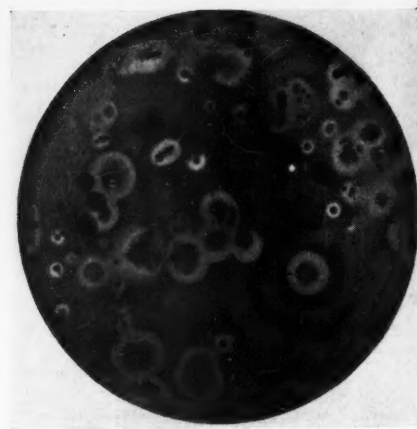
Ultraviolet light has been proposed for diluting the bacterial density of operating rooms, as contrasted to the devices for sterilizing the air in the immediate field of operation. While tests of the air in the room seem to offer interesting suggestions, the whole matter of the importance of these bacteria of the air to operating room infections is too problematic to justify the wholesale installation of ultraviolet air treatment in hospitals. More experimental and practical information is greatly needed along these lines.

Contamination of the operative wound by bacteria of the air is not by any means the only danger to be avoided. The major item of impor-



**Left:** Cap and mask made in one piece. Flexible metal is inserted in the seam at the lower margin of the opening for the eyes. The mask completely covers the hair, ears, nose and mouth.

**Opposite Page:** Cart for surgical dressings. Note box provided for the basin of antiseptic solution.



**Right:** The numerous colonies of various organisms which accumulated on the surface of a blood agar plate during an exposure of thirty minutes in an operating room. A violent dust storm was in progress while this exposure was being made

tance is keeping and handling the instruments and materials so as to avoid their becoming contaminated in the room in the course of the operation, assuming them to be sterile when delivered to the room.

There are three items of a general nature which should be observed: (1) the instrument table should be placed out of the line of traffic and as far from the gallery as possible; (2) this table should have a canopy made of sterile sheets, and (3) insofar as is possible, new sterile material should be laid out for each operation.

In busy operating rooms when patients follow each other in rapid succession, it is not necessary entirely to strip the table between patients but the smallest excess material possible should be laid out on the table. It is undesirable to carry over pieces of suture the containers of which have been opened, or gauze sponges, laparotomy sponges, "salts" or drains. Any instrument that has been handled in the course of an operation should be sterilized again for the subsequent one. Insofar as is possible, all materials, including instruments, should be handled with sterile forceps.

Drums in which materials and instruments have been sterilized furnish the best and safest means of keep-

ing these materials sterile during long periods in the operating room. Use of drums also makes it possible to keep at hand excess supplies. It is wise to plan the layout so that by the time three operations are over none of the original material is left on the instrument table. If a long break comes in the sequence of cases a new table should be set, including sheet and pans.

The skin of the patient as a source of contamination has received much attention and a large variety of reagents have been advocated for preparation of the skin. It seems obvious that when the patient is brought into the operating room the area of incision should have been shaved and thoroughly washed with soap and water.

A decision has now to be made as to whether defatting agents, such as benzene, will be used with cutaneous antiseptic substances that are dissolved in alcohol, or whether an antiseptic preparation containing a defatting agent, such as acetone, is to be used. There seem now to be advantages in using a preparation containing acetone and omitting benzene on account of the danger of burns. However, the skin may be wiped with ether if desired. Dyes in the antiseptics serve a purpose; they

show where the antiseptic was applied.

There are several suitable antiseptic substances on the market but selection should be made of one that retains its antiseptic and germicidal activity over a fairly long period rather than of one that becomes inert in a short period. Some of the newer mercurial substances marketed as tinctures have proved to be excellent.

It is still good practice to discard or to resterilize the knife used for the cutaneous incision and to protect with sterile towels the edges of skin about the wound. The whole area may then be covered with a sterile sheet through which an opening has been made, suitable to the size of the incision. Instruments that have come in contact with infective material, such as pus or intestinal content, should be immediately dropped into basins and removed from the operating room.

There are in use a number of sharp-edged instruments that are sterilized to advantage by the cold method. Several suitable solutions are available but it should be remembered that sufficient time must be allowed for sterilization to take place and that the instrument should be washed clean and dried before being placed in the solution. There is no known antiseptic so rapid in its action that instruments can be sterilized by merely passing them through the solution. The instruments must be free of protein and enough time must be allowed for the action of the chemical.

Hand basins for the use of nurses and physicians during the operation should be conveniently placed. They should contain an antiseptic substance but the solution should be made up in sterile water. The solutions should be renewed in the course of the operation if much blood or serum is washed off into them, for this rapidly decreases their value.

The order of selecting patients for a given room needs some attention. Clean cases always should precede dirty cases and those in which the bowel must be opened should be placed last on the list. After a room has been used in a case of rapidly spreading infection, a new sterile setup should be made before operating on clean cases. Care in this matter





will serve as a practical check on operating room infections.

Most difficult to control is infection from the personnel of the operating room owing to colds and sore throats. It should be obvious to all that a surgeon, assistant or nurse who has a disease of the upper part of the respiratory tract has no business in the operating room and certainly a visitor who harbors such an infection never should be admitted to the operating suite. No one who has obvious symptoms should be admitted to the operating team and after a person has had a respiratory infection he should be excluded from the team until throat cultures show normal streptococcal flora. Even then an extra thickness of gauze should be added to his mask for several days.

Surgical technic does not end with the operating room but should extend to the subsequent dressing service. There is no justification for insisting on a meticulous operating room technic and then permitting careless and indifferent procedures in dressing wounds.

If surgeons insist on dressing wounds early after operation the technic of dressing will have to be essentially the same as that observed in the operating room. The longer the original dressing is allowed to remain in place the less danger there is of contaminating the wound. In most hospitals it will be best to dress the patient in his room but if a dressing room is maintained the same general rules should apply to it as to the operating room.

If the dressings are done in the bedrooms, then a cart, similar to the one in the accompanying illustration, will be found suitable. A basin of antiseptic solution is provided as well as a pail for waste. The instruments, dressings and drains are handled with forceps that are kept in a strong germicidal solution. The dresser should be gowned and masked and should wear rubber gloves. Since he does not touch anything but the handle of the forceps, it is sufficient that he wash his gloves in the solution between cases and not change his gloves. All dirty cases should be dressed last and, if the service is large enough, two teams should be employed, one for clean and the other for dirty cases.

The cart should be prepared fresh for each day's work and a nurse should be in attendance to push the cart, to open and close doors and to act in the general capacity of a non-sterile nurse. If fiber dressing pads are used, they will require extra precautions in sterilizing because of the large number of spore bearing bacteria sometimes found in them.

Operating room and postoperative infections owing to cross-connections in the water and sewage systems of hospitals have received much attention in recent years. Their importance cannot be overestimated. While this matter is outside the scope of this article, it must be a consideration of asepsis in the operating room; no surgical technic is safe as long as cross-connections between safe and unsafe water supplies, or between safe water supplies and sewage systems, exist. These cross-connections are frequently to be found associated with tanks that are supposed to contain sterile water, with sinks, with instrument sterilizers and utility

sterilizers, with water vacuum irrigation and with siphon arrangements.

Aside from the honest desire on the part of all workers in operating rooms to render service to the patient, there is nothing that so keeps an operating team on the alert as irregularly made and unannounced bacteriologic tests of the material.

In the best hospitals the clinical pathologist is encouraged to examine the room frequently and he should be given full authority to regulate and control the procedures as regards the maintenance of sterility in the operating rooms. He should, at unannounced times, take samples for culturing and inspect everything relating to sterile technic.

While one would not advocate fear as a motive for keeping up a perfect technic, a healthy respect for the clinical pathologist and his findings will do much to eliminate operating room infections. He should be encouraged to criticize every item and procedure and often he will be able to prevent infections.

## They Do It, Too, in Australia

APPROXIMATELY ten years ago, a meeting was held in Melbourne, Australia, of American women who were resident in that city. Most of them were the wives of business men, either permanently or temporarily stationed in Melbourne. The object of the meeting was to discuss the question of forming an American women's auxiliary to help the Children's Hospital and it was agreed that it should be put into operation immediately. Mrs. J. W. Dye, whose husband was then American consul, was elected president and it since has been the general rule that the wife of the consul should act in that capacity.

This American women's auxiliary has functioned in an extraordinary way and, to date, the hospital has benefited to the extent of about \$40,000. The main function of the year is the Independence Day Ball held on the fourth of July, in the middle of winter. The Children's Hospital benefits by the net proceeds.

The decorations in connection with

the ball are an outstanding feature. In order that the hospital may benefit to the fullest extent, collections are taken up from American firms in Melbourne to defray expenses of the decorations.

In 1937 approximately 1500 tickets were sold at \$3 each. Last year the women decided to eliminate entirely all complimentary tickets, so that henceforth even the American consul and his wife will have to pay admission. The hospital received a check for more than \$5000 as representing the proceeds of the last Independence Day Ball.

In addition to this, the American women's auxiliary provides numerous garments for the patients in the hospital and always makes a special effort at Christmas in the way of donating toys to brighten the lives of the children during this season.

This auxiliary, which has a membership of 40, is one of 43 that assist the Children's Hospital. The total membership of all the auxiliaries is approximately 5000.



# Handling Patients' Complaints

SAMUEL PARLETT

FORMER patients from many hospitals remember their period of hospitalization as a disagreeable interlude over and above the discomfort occasioned by illness. Ask the chronically ill patient who has knocked about in general hospitals in his time and he will tell you. Some emerge dispirited and humiliated or resentful of the treatment to which they have been subjected.

The patient who is discharged cured can soon find comfort in his restoration to normal life and forget his experience, like the woman who forgets the pains of childbirth. Not so, however, with the patient whose experience with hospitals must be continuous.

So we find that patients who, because of the nature of their illnesses, need further treatment in an institution from which early discharge is improbable come to these institutions in a state of apprehension. Since they are recipients of the institution's bounty, they accept what they regard as inevitable, profiting meanwhile by the lessons in submission that they learn during their hours of enforced idleness.

## No Avenue of Protest

Chronic disease patients find themselves subjected to the same thoughtless treatment by employes that sometimes may be found in general hospitals, except that the attendant is likely to be callous because he becomes inured to the hardships of those whose illness does not readily respond to treatment. Food is often poor and unappetizing. Encroachments on the patient's rights either by employes or by fellow patients cannot be successfully protested through any administrative department, because of the apparent lack of machinery to make the necessary adjustments.

The purpose of this article is, however, not to draw up an indictment but to illustrate how an institution,

The author is chairman of the Patients' Welfare Council, Montefiore Hospital.

whose board of trustees and administrative officials have an active sense of responsibility in regard to the basic human rights of patients as well as employes, can do much to diminish the more serious consequences of this situation.

Steps were taken in Montefiore Hospital for Chronic Diseases, New York, years ago to add a new branch of organization that would help obtain fair treatment for all patients. A carefully selected patient was made liaison officer and invested with the right to concern himself officially with the welfare of the patients as a whole. He was given permission to make rounds on the wards, as he thought necessary, for the purpose of interviewing his fellow patients at their bedsides or in a special office assigned to him. The complainant was assured a hearing without prejudice by the administration, which would then act, in any situation involving difficulties between patients

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**Realizing that the patient is a sensitive human being as well as a medical problem, Montefiore Hospital, New York, has an arbiter for adjusting patients' relations with personnel**

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and employes or patients among themselves, on the merits of each case.

It was established as a basic operating principle that no person, no matter what his relation to the hospital, was exempt from the requirement of treating patients with proper courtesy and consideration. To help remove the tendency toward favoritism on the part of the attendant staffs, the rule that the giving or accepting of gratuities in any form

was an act rendering both the donor and the recipient liable to discharge was enforced. From the beginning the principles involved in this program have been carefully observed.

In its early days, there was much resentment on the part of the staffs. Many rebelled because it seemed to cramp their style and made it necessary for them to acquire a more patient and a more tolerant point of view. Since this activity centralized about the personality of a patient, many employes thought that the tendency toward readjustment had moved too much in the opposite direction and that the scales were weighted in favor of the patients to the detriment of the best intentioned employes.

## Fairness Is Acknowledged

With the passing of time, however, this attitude was modified partly through the removal of those unwilling to conform but mostly through the slowly growing realization of those who remained that the fundamental purpose of this activity was to establish a condition fair to everybody. Department heads, without exception, have recognized the intrinsic fairness of the arrangement, often making it a point to go out of their way to consult with the liaison officer on matters in which patients might find themselves in difficulties, whether between patients and employes or among themselves.

The operation of the system is simple. The liaison officer, known officially as the chairman of the patients' welfare council, is at all times available for the purpose of hearing complaints that patients may have to make. He acts upon these complaints at his discretion. Usually, because of his acquaintance with all the patients of the hospital, he is able to judge how much credence may be placed in any story that may be brought to him. If the complaint is made

against some employe who had always enjoyed a reputation for good service, it is obvious to him that the story of the patient may not be altogether credible.

By accumulating supporting evidence relating to the actions complained of, it becomes possible for the liaison officer to take the matter up with the head of the department to which the erring employe is attached or with one of the administrative officials. If, in the judgment of the liaison officer, the employe is unjustly accused, he makes it his business to acquaint the complaining patient with his judgment in the matter. If the patient has been guilty of an unjustified attempt to involve an innocent employe and the matter is sufficiently important to justify such a course, the liaison officer may even recommend disciplinary action.

In complaints of patients against other patients, the chairman may make an adjustment between them. If the matter requires fundamental adjustment or if the complaint is against a patient who is deliberately objectionable to his fellows or to the employes, the liaison officer may refer the matter to the administration with his recommendation for disciplinary action.

#### **No Distinctions Permitted**

As practiced in this hospital, the liaison officer makes it his business to visit the wards periodically, going from bed to bed and talking personally with each patient. Fundamental to his relationship with them is the fact that he must not be regarded by them as an instrument in furthering personal animosities and that he makes no distinction between one patient and another in the handling of any complaint.

For the smooth working of such a plan it is imperative that the liaison officer be regarded by the patients as a fair-minded friend and by the employes as one who is equally interested in their welfare. Any difficulties arising between visits of the liaison officer to the wards may be handled either by a report of the patient directly to the liaison officer in his office or by a call to him to appear at the bedside of any patient not able to leave his ward.

It is of utmost importance that

under this arrangement there be no reprisals by anybody against a patient who has made a complaint in good faith, a precaution that requires constant vigilance. An employe who knows himself to have been complained against by a patient may, because of the turn the matter has taken, feel safe in "taking it out" on that patient; he must be held accountable for his actions. Vicarious reprisals must be dealt with similarly. For example, if a patient lodges a complaint against an attendant, other employes might think it advisable on general principles to let him know it, all of which must have adequate safeguards.

#### **A Responsible Post**

In a general hospital the work of a liaison officer should be entrusted to a member of the salaried staff, with rank equivalent to that of an assistant director. This is because the average stay of a patient in a general hospital usually is a short one, during which he is too ill to accept responsibility.

It should be the duty of the liaison officer to make frequent rounds through the hospital, interviewing patients at their bedsides. Because of their brief stay within the hospital there are likely to be few office interviews with patients desiring to register complaints. Furthermore, because of the short period of hospitalization and the necessity for quick settlement of any difficulty, the liaison officer should be given authority to take whatever remedial measures are necessary on his own initiative, being responsible for his acts to his superiors in the same manner as he would be in relation to any other type of work.

The effect of this program on patients is to give them a feeling of security. There will always exist, however, patients who are distrustful and cannot be convinced that the cure for imposition is an honest discussion. These, while they may not make direct complaints, are, nevertheless, benefited by the improvement in the conditions affecting all patients. At the other extreme are patients who may try to utilize the system to establish areas of domination of their own on the theory that they will be protected in any case and

patients who wish to correct trifling or nonrepetitive lapses in service of a sort that are inherent in even the best regulated social schemes.

Employes who have been the subject of well-founded complaints by patients are dealt with in accordance with the nature of the offenses of which they are guilty. If the department head feels that the employe's offenses were not intentional, he is admonished and told how to mend his ways. In cases in which no extenuating circumstances can be found, the employes are dealt with summarily.

The liaison officer is assured full cooperation by the administrative head of the hospital. He has the right of appeal from any decision rendered by a department head and may take the case for consideration to the office of the administration.

The complete approval of this program by our board of trustees and the full cooperation given it by administrative officials have resulted in a well-balanced relationship between employes, staff members and patients. This is not to say that abuses never occur and that unfairnesses do not exist. There are always employes who, in spite of definite instructions to the contrary, will attempt to test out the efficacy of the plan.

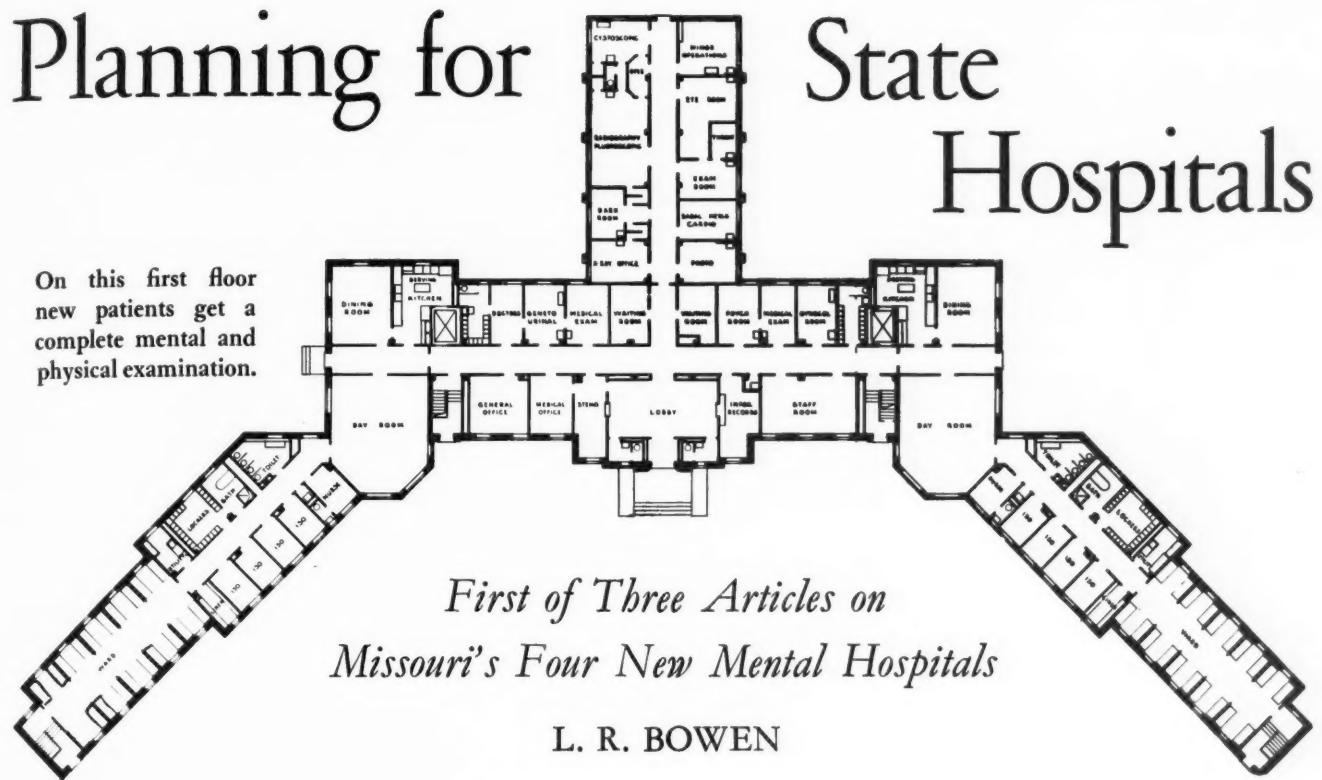
#### **Policy Is Inflexible**

But with an administration dedicated to the principle of correcting these abuses, they tend not to recur and any individual attempting to create a situation contrary to the established policy quickly finds himself on the defensive. There are also patients who will take advantage of the situation, trying to bend the program to their own ends. These, too, quickly find that such behavior is frowned upon and will not be condoned by the administration.

Human nature being what it is, patients find plenty to complain about but, whereas in many instances in the hospital world patients complain about neglect, insult, extortion and even actual violence, in this hospital most complaints relate to the temperature of the soup, the radio program, the moving pictures and whether or not the windows are open too much or too little to suit the individual's taste.

# Planning for State Hospitals

**On this first floor  
new patients get a  
complete mental and  
physical examination.**



*First of Three Articles on  
Missouri's Four New Mental Hospitals*

L. R. BOWEN

THE state of Missouri is just completing a program for the rehabilitation and extension of its eleemosynary and penal institutions. Funds were supplied in part by a state bond issue and in part by P.W.A. grants, amounting to approximately eight million dollars. The work has been done under the direction of a technical staff reporting to a bipartisan advisory board, selected by the state building commission, a group that consists of the elective state officials.

The scheme of operation has been for the technical staff to prepare sketch plans, showing the functions and arrangements of the different building units, and to employ firms of architects to develop the detailed plans and specifications. About 34 firms of architects have been employed on the eleemosynary program. The letting of the contracts and supervision of the work have been done by the technical staff.

The eleemosynary institutions included in the state building program were the four mental hospitals, the state sanatorium for the tuberculous, the state school for feeble-minded and the state home for children. The four mental hospitals have a total

The author was supervising architect of the Bipartisan Advisory Board, Missouri State Building Commission.

population of about 7600. The city of St. Louis maintains a separate institution for the mentally ill accommodating 3400. Only the work done at the four state mental hospitals will be discussed in this article.

State Hospital No. 1 at Fulton, State Hospital No. 2 at St. Joseph and State Hospital No. 3 at Nevada are of the Kirkbride type. State Hospital No. 4 at Farmington is of the cottage or detached building type. All of these hospitals were crowded and none of them was of modern fireproof construction.

The following objectives were set out for accomplishment in the building program: (1) to relieve overcrowding; (2) to provide proper reception facilities for new patients; (3) to house at least the infirm and tuberculous in fireproof buildings; (4) to provide proper medical-surgical facilities; (5) to provide facilities for the treatment of the chronic disturbed.

In planning to relieve the overcrowding at the four mental hospitals, it was necessary to know their normal capacity, their present popu-

**Table 1—Overcrowding in State Hospitals Before Remodeling**

<i>State Hospital</i>	<i>Normal Capacity</i>	<i>Patient Pop.</i>	<i>Overcrowding No.</i>	<i>Per Cent</i>
Fulton.....	1465	1708	243	16.6
St. Joseph.....	1726	2432	706	40.9
Nevada.....	1144	1618	472	41.3
Farmington.....	649	1139	490	75.5
Totals.....	4984	6897	1911	38.3

**Table 2—Housing Classification of Patients**  
(In Percentages of Population)

	<i>July 1934</i>	<i>February 1935</i>	<i>Adopted for Design</i>
On Receiving Wards.....	6.1	6.1	7.5
Quiet Able-Bodied.....	39.8	45.9	40.0
Infirm.....	19.4	16.9	20.0
Disturbed.....	22.9	20.1	20.0
Acutely Ill.....	3.4	2.8	3.5
Epileptic.....	6.2	4.9	6.0
Tuberculous.....	2.3	3.3	3.0



**Table 3—Movement of Patient Population in State Hospitals for Mental Diseases, 1926 to 1936**

Years of Census	Population of United States	Number of Patients in Hospitals	Number per 100,000 Pop.	Admissions		Discharges		Deaths	
				Number	Per Cent of Patients	Number	Per Cent of Admissions	Number	Per Cent of Admissions
1926	116,531,963	246,486	211.5	65,348	26.5	32,036	49.0	25,315	38.7
1927	118,196,785	256,858	217.3	69,318	26.9	34,662	50.0	24,692	35.6
1928	119,861,607	264,511	220.7	73,388	27.7	36,373	49.6	26,492	36.1
1929	121,526,429	272,252	224.0	75,601	27.7	37,432	49.5	27,866	36.9
1930	123,091,000	280,251	227.7	78,452	28.0	38,538	49.1	26,923	34.3
1931	124,113,000	292,284	235.5	82,334	28.1	39,974	48.6	26,794	32.5
1932	124,974,000	305,031	244.1	83,450	27.4	40,813	48.9	27,210	32.6
1933	125,770,000	321,824	255.9	86,407	26.8	41,898	48.5	27,517	27.4
1934	126,626,000	332,094	262.3	87,647	26.4	46,383	52.9	29,098	33.2
1935	127,521,000	342,167	268.3	89,964	26.3	46,090	51.2	29,297	32.5
1936	128,429,000	353,604	275.3	94,897	26.8	48,420	51.0	32,004	33.1

Notes: Patient population taken as number in hospitals at beginning of year.  
Admissions include first admissions and re-admissions but not transfers.  
Discharges do not include transfers.  
Deaths include patients in hospitals.  
Population of United States as per estimates by Bureau of the Census as of July 1.

lation and the rate of growth of their populations. The first two items are shown in table 1.

The normal capacity was determined solely on the basis of housing facilities. For each bed of normal capacity it was assumed that 50 square feet of floor space would be required in dormitories and 30 square feet, in day rooms.

From the annual reports of the hospitals it was noted that the rate of growth of the residual population was increasing faster than the whole population of the state. At the beginning of this program the annual increment of patients in the four state hospitals was about 300, while the annual admissions totaled about 2000.

It soon became apparent that, with the funds available, all that could be done was to relieve the present overcrowding without making any provi-

sion for the annual increment of patients. It was considered desirable to limit the normal capacity of the hospitals to 1600 beds each, but as the population of two of them had already exceeded that number it was not found practical to do so. In planning the new extensions it was decided, therefore, to provide normal capacities as follows:

Fulton ..... 2000 beds  
St. Joseph ..... 2400 beds  
Nevada ..... 1600 beds  
Farmington ..... 1600 beds

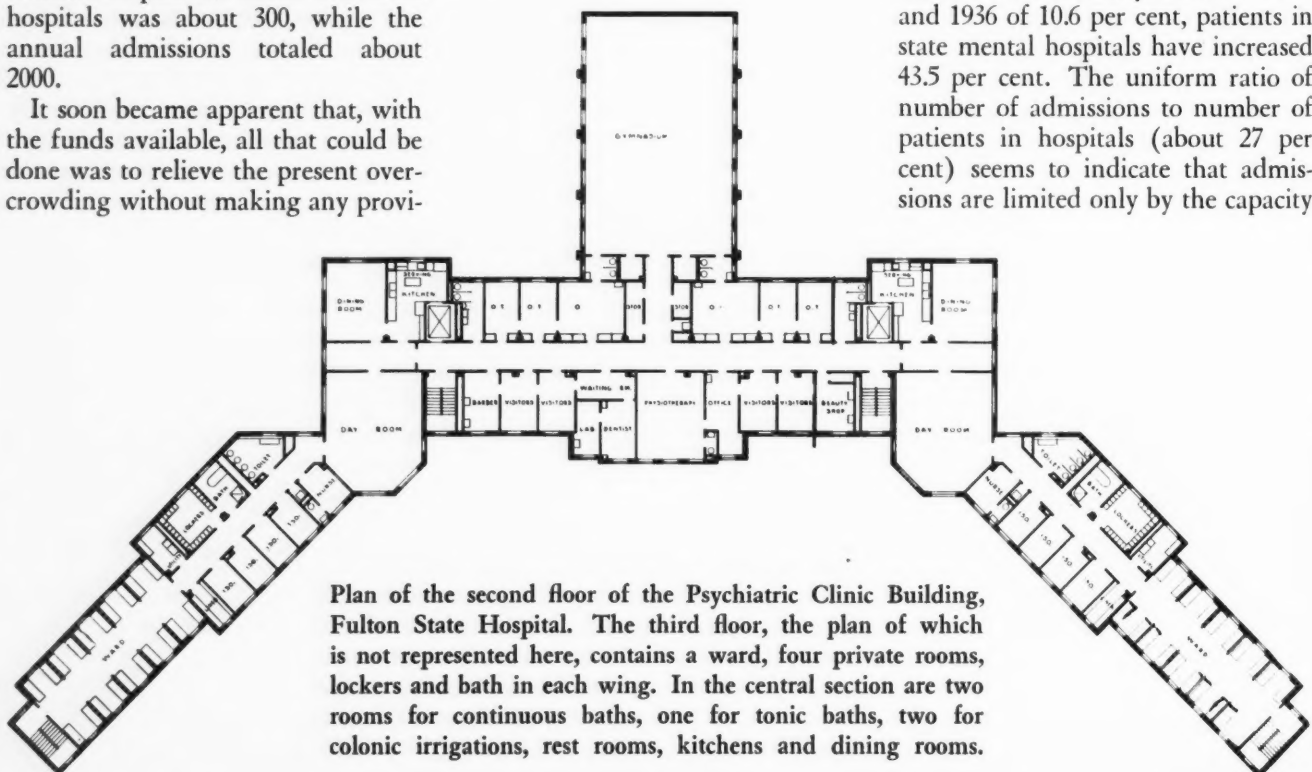
As it was necessary to know the proportions of patients in the differ-

ent housing classes, surveys were made in July 1934 and in February 1935 to determine such proportions. The results of these surveys and the proportions adopted for purposes of design are shown in table 2. In listing the number of disturbed patients, the occasionally disturbed were not included but only those generally disturbed.

While it is commonly known that the number of male patients exceeds the number of female patients in most mental hospitals, it was noted that both surveys showed the number of female disturbed to exceed the number of male disturbed by about 71 per cent. For purposes of design this excess was fixed at 50 per cent. A preponderance of males was found in the quiet able-bodied group.

The statement is frequently made that mental patients fill one-half of all hospital beds in the United States. Statistics published by the Bureau of the Census show marked increases of mental patients in institutions for each succeeding census since the first complete survey was made in 1904. The essential facts of such statistics as they pertain to state hospitals have been brought together in table 3 for the years 1926 to 1936, inclusive.

It will be noted from table 3 that, with an increase in the whole population of the country between 1926 and 1936 of 10.6 per cent, patients in state mental hospitals have increased 43.5 per cent. The uniform ratio of number of admissions to number of patients in hospitals (about 27 per cent) seems to indicate that admissions are limited only by the capacity



Plan of the second floor of the Psychiatric Clinic Building, Fulton State Hospital. The third floor, the plan of which is not represented here, contains a ward, four private rooms, lockers and bath in each wing. In the central section are two rooms for continuous baths, one for tonic baths, two for colonic irrigations, rest rooms, kitchens and dining rooms.



of the hospitals. There seems to be a definite decrease in the rate of deaths in the hospitals.

The most discouraging information shown by the data, in view of the constantly increasing ratio of patients to population, is that the ratio of discharges to admissions shows no improvement but appears to be fixed at about 50 per cent. An unfavorable feature about the discharges, as shown by the detailed surveys, is the constantly increasing portion of these patients who are without psychosis. In 1926 these amounted to 8.4 per cent of the discharges but by 1935

Typical of the psychiatric clinic buildings is this Farmington structure.

had increased until they amounted to 15.5 per cent of the whole number of discharges from mental hospitals.

The foregoing data suggest that it now is or will become an impossible burden for states to build hospitals of sufficient capacity to care for the ever growing number of mental patients unless methods are devised to increase their effectiveness in preparing patients for discharge. These data influenced those in charge of the Missouri program to provide facilities to aid in early discharge of patients.

In its complete report for the year 1922, the census survey gives the duration of last residence of the 51,304 patients discharged from all mental hospitals. In its similar report for 1933 it gives such time for the 41,898 patients discharged in that year from all state hospitals. These data are combined in table 4.

It would be expected that mental disease, like other pathologic conditions, would respond most readily to treatment in its early stages. However, the figures in table 4, showing that about one-third of those discharged have had a hospital residence of 60 days or less, that one-half of them have been there four months or less, and that six months' residence will include the majority of those discharged, indicate graphically that hope of recovery lies largely in the early treatment.

From these data and from the fact that mental diseases are frequently associated with other pathologic conditions, it seemed that the most effective contribution to the state mental hospitals of Missouri, as far as construction is concerned, would be to provide at each institution a clinical unit equipped with all necessary facilities for making a complete physical and mental examination of each new patient. In each clinical unit would be included all known facilities for treating mental illness in its

**Table 4—Duration of Last Hospital Residence of Patients Discharged From Mental Hospitals**

Duration of Last Residence	During 1922		During 1933	
	Patients Discharged	Accumulated Per Cent	Patients Discharged	Accumulated Per Cent
Under 1 month.....	10,216	19.9	3,307	7.6
1 month.....	6,484	32.6	5,401	20.8
2 months.....	4,907	42.1	4,219	30.8
3 months.....	3,842	49.6	3,844	40.0
4 months.....	2,931	55.3	2,875	46.2
5 months.....	2,447	60.1	2,223	52.2
6 months.....	1,973	63.9	1,855	56.6
7 to 11 months.....	5,908	75.4	5,539	69.8
1 year.....	6,040	87.2	4,964	81.7
2 years.....	2,224	91.6	1,921	86.3
3 years.....	1,190	93.9	922	88.5
4 years.....	729	95.3	571	89.8
5 to 9 years.....	1,533	98.3	1,185	92.7
10 years and over.....	770	99.8	673	94.3
Unknown.....	110	100.0	2,399	100.0
Totals.....	51,304		41,898	



early stages. The largest ratio of personnel to patients would be concentrated there, and pleasant living quarters would be provided, apart and away from any chronic patients, of capacity sufficient to house all hopeful new cases for the time necessary to provide for the recovery and discharge of the majority of them.

Such units, designated as psychiatric clinic buildings, were provided for each of the mental hospitals and designed of a capacity equal to  $7\frac{1}{2}$  per cent of the normal capacity of such hospitals. With an average admission rate of 30 per cent of normal capacity, a discharge rate of 50 per cent of admissions and a death rate of 30 per cent of admissions, such a capacity will allow patients who are not previously discharged to be treated in the clinic for six months before making it necessary to transfer them to the "continued treatment" wards of the hospitals. It is not expected that newly admitted seniles or patients who are critically ill will be housed in the clinic; they will be transferred immediately to the infirmary or hospital buildings.

Each psychiatric clinic is so located that it faces away from the chronic group, that direct access to it can be had from outside roads without passing through the general hospital grounds and that each has its own tributary area of some 6 acres or more of land that can, by landscaping, be isolated from the chronic group.

It also will be noted that each clinic is conveniently connected by a pedestrian tunnel with the hospital building and the infirmary building of the institution it serves, to facilitate easy transfer of patients.

Each of these units (except the one for the hospital at St. Joseph, which has a kitchen and wards for colored patients in the ground story) is three stories in height. The clinic proper occupies the center section, while the living quarters of the men and women patients extend in wings to the left and right of the center. Each of the six patient units has a ward two beds wide and of a capacity of either 16 or 20 beds, divided into two-bed cubicles by dwarf partitions with a window between each two beds.

The isolation or individual rooms are either four or six in number and



Dormitory with two bed cubicles at psychiatric clinic, Fulton State Hospital.

are located in the utility sections between the day rooms and the wards. The utility sections have separate toilet and bathrooms, the latter being located adjacent to and connected with the locker rooms, where an individual locker is provided for each patient. The nurse's room in the utility section has a window looking upon the day room, but the room opens into the utility corridor so that the utility section and isolation rooms may be locked off from the day room at night or the ward rooms in the daytime. The usual linen and utility rooms are in this section.

There are a dining room and serving room for each patient unit and food is brought to the serving rooms directly by elevators which lift the insulated carts from the basement tunnel that connects with the main kitchen. These elevators also serve as passenger elevators for the clinic.

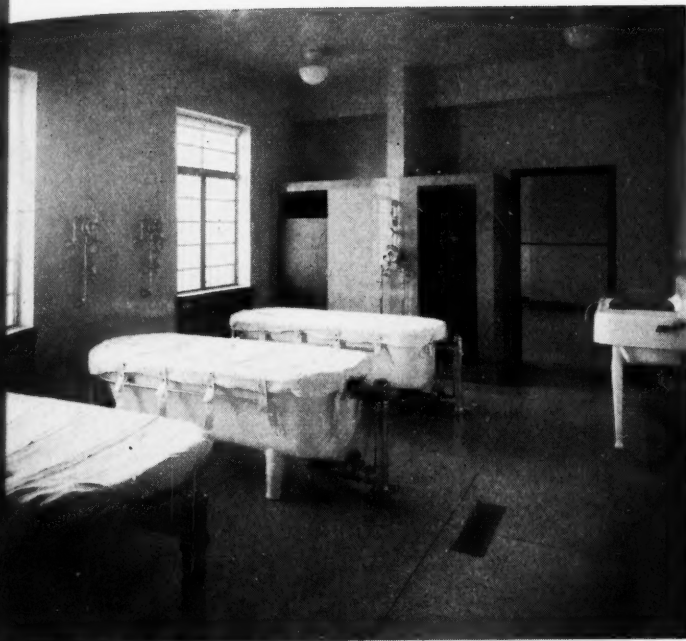
Steel detention windows, casement type with transoms, all opening outwardly a fixed distance and controlled by removable handle operating devices, are used throughout. Copper fly screens, divided into three units, covering the full height of the windows, are placed on the inside and are not to be removed except when the windows are cleaned.

In the third story, where it is planned to house disturbed patients, these fly screens are made of No. 22 gauge galvanized steel wire, 14

meshes to the inch, and mounted in  $\frac{1}{2}$  by 1 inch solid steel frames hinged on one side and secured on the other with prison type screws. These are intended to prevent patients getting to and breaking the glass of the windows. Detention fly screens alone form effective window guards. There was some fear that the heavy wire of these screens might reduce visibility and light to an extent to be objectionable, but they have proved satisfactory.

The first floor of the clinic section has the usual hospital arrangement of entrance lobby and adjoining information and record room, conference or staff room and offices for the medical staff and secretary. Separate waiting and examining rooms are provided for men and women patients. The examining rooms include general medical examining rooms, psychiatric clinic room, gynecologic room and genito-urinary room.

To the rear of the center section there are also a photography and fingerprint room for the recording of new patients; a basal metabolism and cardiographic room; an examining, treatment and dark room for the eye, ear, nose and throat specialist, and a minor operating room. There is also in this section a radiographic department, including the office and viewing room, dark room, radiographic and fluoroscopic room and cystoscopic room.



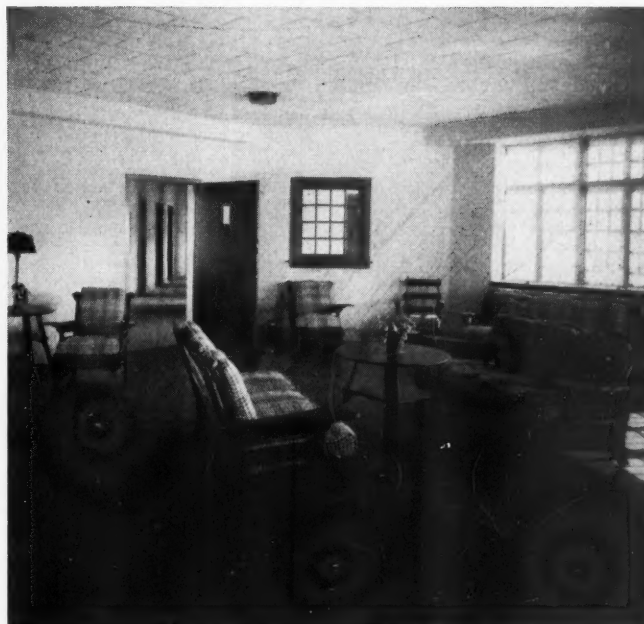
View of sedative bath room, Fulton State Hospital.

The necessity of establishing a complete radiographic unit in this building may be open to question. It is necessary, of course, to provide the complete examination for which this unit is established. It was my thought that it should be included and that, after the system of making a complete examination of all new patients has been in operation for a few years, there will not be need of having so complete an installation elsewhere. Its inclusion in this building was concurred in by the management of the several hospitals, possibly because none of the hospitals had a complete or modern installation.

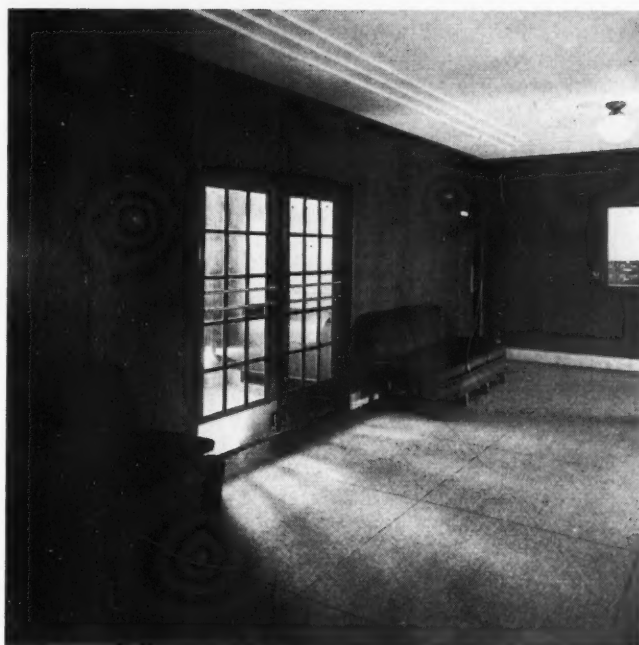
As it was necessary to build two new acute disease hospitals, the planning of them brought up the question of installing additional x-ray units, which became a matter of serious concern. This is discussed later in the description of hospital buildings.

On the second floor of the clinic section a physiotherapy department has been established and a dental department and beauty and barber shops installed. Between these units a number of visitors' rooms is provided, so connected that at times they may be used as waiting rooms for the foregoing units. On this floor also is provided a number of occupational therapy units of varying sizes, those for men and women each

**Above, right: A cheerful waiting room, tastefully furnished, in one of the Missouri psychiatric clinics.**



**Right: The main entrance lobby for patients and visitors at the psychiatric clinic building, Fulton, Mo.**



connecting directly into a large hall or gymnasium. These are intended for educational, recreational or work programs devised by the doctor.

The third floor of the clinic section, which adjoins the wards where it is planned to house disturbed patients, is devoted entirely to hydrotherapy. On both the men's wing and on the women's wing sedative hydriatric suites, consisting of colonic irrigation, continuous bath tubs and pack rooms, have been installed. At the center of the section there is a tonic bath room to be used on alternate days by men and women; this is connected with separate rest and recrea-

tion rooms. This room has been equipped with various douches, sprays with necessary control equipment, saline, sitz, arm and leg baths and an electric light bath.

Although the psychiatric clinic buildings have all been developed from the same general preliminary plan they vary in cost from a minimum of \$2329 per bed at Fulton State Hospital to a maximum of \$2736 per bed at Nevada State Hospital. This is due to variations in the materials of construction and cost differences at the several locations.

A description of the hospital buildings will be given in a later issue.



**W**HY have a hospital medical library? This question has been heard many times. It was frequently asked a year or two ago when plans were being considered for improving the medical library service at Cook County Hospital, Chicago.

The hospital is favorably situated for getting along without a library since it is surrounded by medical libraries—bounded on the south by the college of medicine of the University of Illinois, on the west by Loyola University and on the northeast by Rush Medical College. The interns, many of them former students of Illinois, Loyola and Rush, could feel quite at home in these institutions although some protests were heard in neighboring libraries that county interns took up too large a portion of space and kept the collections of books and journals from being used to their full extent by the students. However, it was thought by some that the hospital was not suffering particularly from the lack of a library service within its walls.

Now that Cook County Hospital has one of the best medical libraries enjoyed by any hospital staff perhaps it will be of general interest to answer the foregoing question. A small, carefully chosen collection of books and journals in our hospital, as in our home, often serves us better than a larger collection at a distance, no matter how short that distance may be.

The argument may be advanced that the hospital should not have to pay for books for the doctors to read. We may even hear the facetious remark that we do not have to make it any easier for doctors to write papers since there is already too much being written. In establishing adequate library service in any hospital, benefit to the hospital is the primary consideration. It is the hospital that suffers from an impoverished library rather than the doctor. If a doctor wishes to write a paper he will find reading facilities to meet his needs somewhere and in due time. The medical staff benefits greatly from the hospital library, but this may be considered of secondary importance. No hospital would have



## Medical Library

STELLA FORD WALKER

to consider establishing its own medical library if it were not true that such a library pays for itself in benefits directly to the institution.

An adequate medical library will benefit every department in the hospital, will benefit the hospital as a whole, will improve the care of patients in the hospital. There are questions coming up every day in every hospital, in every department of the hospital, that may be answered in the hospital library. The various laboratories, the x-ray department, social service, dietetic service, nursing service and administrative departments, as well as individual doctors, look to the hospital library for information even if there are useful books on the desks and on the shelves in the various departments. If these questions do not receive a ready

answer, the departments are handicapped to that extent.

Frequently a doctor will step into the library to learn the method of treating a patient suffering from a disease not often encountered, to refresh his mind regarding a surgical procedure or to verify his recollection of proper dosage.

The hospital medical library is the proper repository for the reports from the various departments of the hospital, the reports of staff meetings and the annual report of publications by members of the staff. There is no other place where these reports and studies will be read as frequently or prove of as great use as in the hospital's own library.

In a large hospital with a complete group of medical services, such as are associated in Cook County Hos-



# Service Pays

and DOROTHY BARTELS

pital, the library collection must include a few of the latest texts and journals for each of the specialties as well as those for general practice.

Our subscription list and initial list of books were compiled in the following manner: a number of titles of books and journals for each specialty were sent to the chief of each of the special staffs requesting that he discuss the list with the attending men in his group and check those considered most essential. When the answers were received we had a list much too large in proportion to our appropriation. This was reduced by elimination of the following books: very old books, those out of print and those that were to have a new

edition in the near future. Then the list was further reduced by careful checking by the medical superintendent, Dr. Karl A. Meyer. We also had the benefit of the suggestions of the library committee of the Cook County Hospital Intern Council. This committee saw to it that the most practical books for every day reference were included.

The same procedure was followed with the journal subscription list. We have received many requests for these lists and still they keep coming in. However, each hospital is best served by a "tailor-made" library.

The county commissioners made provision for these current journals and for new textbooks and have kept the collection up to date. They have recognized the benefit the hospital derives from a continuous inflow of

new material and have provided in the budgets of the last two years for renewals of journals and purchases of new books.

The collection of books and journals is supplemented by an extensive file of reprints. These reprints are classified according to the *Quarterly Cumulative Index Medicus* and now fill 30 letter size filing drawers. The reprint collection presented by Dr. Bernard Fantus, chairman of the medical library committee, and the large number of reprints presented by the American Medical Association Library formed the nucleus of this collection. Quine Library of the University of Illinois also has contributed reprints and clippings. A smaller file of reprints and clippings is kept according to author and includes only articles written by members of the staff.

While the greatest interest in any library centers in the current literature, it also is of great importance to have, as a substantial foundation, a comprehensive collection of older standard books, the works of the masters of former periods of scientific progress and files of the leading medical journals covering a period of years. Such a valuable foundation was furnished the Cook County Hospital Library in the collection of 600 books and of journals assembled by the late Dr. M. L. Harris, recently presented by Mrs. Harris.

The library is centrally located near the administration offices in the main building. The room, approximately 25 feet by 30 feet, is well lighted by large front windows. Shelves built along two sides of the room accommodate current journals and recent textbooks. A built-in counter serves as a desk for charging out and returning books.

Book shelves, the window seats that are built over the radiators, window frames and door frames are painted a peach-tinted buff, walls are a warm cream color and the high ceiling is a cream gray tint, which seems to make it lower and gives the room a cosier, less institutional appearance. The floor is completely covered with dark brown felt, which is decorative, more durable and costs

The authors are chief statistician-medical librarian and assistant librarian, respectively, Cook County Hospital, Chicago.



about one-half as much as the cheapest grade of carpet. It deadens street and room noises to an appreciable degree.

The furniture is maple. Two reading tables, each 36 by 72 inches, are a convenient size for group study and are well lighted by two large lamps. Two lounge chairs and a sofa upholstered in dark brown, 12



Above: The collection of books and medical journals is supplemented by an extensive file of reprints. Besides the regular reprint collection, the library maintains a smaller file of clippings and reprints of articles written by the medical staff members.

An interior decorator was called in to redecorate and refurnish the library, the funds having been provided by the Cook County interns' alumni association.



straight back chairs, two floor lamps and the librarian's desk complete the furnishings, with the exception of the filing cabinets.

It is a significant and an inspiring fact that Cook County Hospital Intern Alumni Association contributed a fund toward the redecorating and refurnishing of the library. All of the work was supervised by an interior decorator. If obtaining information is a duty owed the hospital, it becomes a pleasant duty in these surroundings.

The type of service rendered by the medical librarian in a hospital varies greatly. She may serve merely as a custodian of books and journals while performing many other duties with little or no relation to library work. On the other hand, a librarian with training and experience in the medical field can be of great service in compiling bibliographies, and in abstracting and translating material on medical subjects. She can help to locate promptly information needed daily by the hospital personnel in response to telephone calls or personal requests.

Such service is of value to the doctors using the library. Frequently, in smaller hospitals, the librarian has part of her salary paid for by individual doctors requiring such service. However, the benefit to the hospital and its various departments

justifies the employment of a trained librarian for part-time or full-time depending upon the size of the hospital. If certain studies are beneficial to individual doctors and are directed and supervised by them, the librarian supported by the hospital may still be rendering full service to the institution by taking an interest in the studies and by assisting doctors doing research. With a library of its own a hospital can adjust hours and type of service to fill its own needs.

At Cook County Hospital a librarian to care for the collection and to render the greatest possible service is on duty during the day and an attendant recently has been employed to keep the library open evenings. The library is open from 8 a.m. to 10 p.m. from Monday to Friday, inclusive, and from 9 a.m. to 5 p.m. on Saturdays. The evening hours are the most useful to members of the house staff. In the first three and one-half months after beginning evening service our records show an attendance of 1112 readers, 550 of whom made use of the library between the hours of 5 p.m. and 10 p.m. Loans are made only to members of our own staff although anyone is welcome to use the reading room. These loans are made only for the week ends.

As far as actual operation of the medical library is concerned, prac-

ticality governs all the procedures. The system of classification is the one devised by Eileen R. Cunningham of Vanderbilt University Medical Library. This system is easy to use and entirely adequate for a library that is limited to medicine and the allied sciences. Time has not been spent on elaborate filing systems.

In few hospitals has the library been coordinated with the medical record room to the extent enjoyed at Cook County Hospital. The library and record room are on the same floor, although not adjoining. Inspiration for many of the studies made in the record room originates in the medical library; likewise, studies in the record room are supplemented by similar material from the literature. Statistical studies from our own case records become more significant and useful when presented along with comparable data from other institutions.

As the use of the medical library increases, the study of case records increases and the improvement in current records becomes more rapid. Instead of a vicious circle of disinterest and neglect there is a magic circle, complete, inspiring and effective. Interest in current literature and in study of case records is not an end in itself but inevitably means improvement in hospital efficiency and in the care of patients generally.

# New York's New Nursing Law

"SEND full particulars of the new Nurse Practice Act to me by wire." This telegram, read at a recent meeting of the New York State Hospital Association, was a humorous incident of that day's session. The laughter provoked was over the collect charges that the telegraphic request would have landed at the door of the unsuspecting correspondent. Some idea of the windfall that would have come to the telegraph company may be gathered from the length of the bill. In a reduced size and condensed into small type, the new law occupies 24 pages.

Certain aspects of the law are confusing and have been widely misinterpreted. For example, it is claimed that the act will elevate the practical nurse into direct competition with the registered nurse. It is also claimed that the new act will put the practical nurse out of business altogether. Neither of these opposing statements has factual grounds in the law itself.

The simple truth of the matter is that the new act in its entirety represents a belated attack on a legislative slack that nurses as a profession should have taken up long ago. Some twelve other professions in New York State alone, including the medical profession's own licensed protection against the fake or the quack, have long since established similar laws on state statute books. These, we, as hospital administrators, have long observed.

## A Forward Step

The particular new law in question may not be ideal, but it is a step in the right direction in that it offers, however belatedly, a similar health protection to the public. As such, it deserves our support however inconvenient it may seem to be forced to purge our present nursing staff of those whose credentials fall short of its requirements.

The new law has significance outside New York State since it is strik-

JOHN HAYES

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**The administrator of Lenox Hill Hospital, New York, clarifies confusing aspects of New York's new Nurse Practice Act, which has been widely misinterpreted. He defines the status of the registered and of the practical nurse today**

---

ingly typical of legislation now being sought by groups of registered professional nurses of other states for their own statute books. This widespread interest was reflected in the numbers of letters that came to the New York State Nurses' Association when it became known that the proposed new law originated within that group.

Briefly, what does the new act ask of hospitals? The answer is clear-cut: after July 1, 1940, every hospital in New York State will be restricted to the employment of nurses licensed by the state. No person will be allowed to nurse for hire, unless he or she has one of the two licenses stipulated by the law.

One of these will be the registered license denoting, as now, the registered nurse. The other, which the act establishes for the first time, is the "practical" license. This is for the practical nurse. For each of these nurses there are sharply defined stipulations covering not only nursing duties, but education and training.

Penalties for the person with a practical license who attempts to pose as a registered nurse or to presume to nurse in any classification other than her own are given in detail.

Thus, no person unauthorized by the state to practice nursing for hire can be employed by any hospital for bedside nursing duties. The law is equally emphatic that each type of nurse, if and when employed, must be restricted to his or her own classification as designated by the license.

The most sweeping change from the hospital's point of view lies in this enforced discontinuance of employment of any or all nurses without a New York State license. The acceptability of their nursing service and training (or the holding of a registered license obtained outside this state) does not alter the case. To conform with the law, the nurse in New York State must qualify for employment with a license for her type of nursing, registered or practical. (This law is similar to the practice acts of other professions in this and other states in this respect, that, despite the fact that out-of-state graduates are licensed in their home states, they must also obtain a license in New York State, if they wish to practice there.)

## Exchange of Licenses

There is good news to be found in the law for nurses within various classifications. One change will affect more than 500 nurses of the state who are graduates of training courses in state institutions now discontinued. Up to July 1, 1940, they may exchange their present licenses as trained nurses for a license as a registered professional nurse without examination. If application for this exchange is made after the date given, an explanation that is acceptable and satisfactory to the commissioner must be made for the delay.

Until this date, the state will continue the examinations for trained nurses under the old act, affording an opportunity for those who have completed the course to win their trained nurse license. This is done to avoid leaving this student group stranded without a rating comparable to the one for which they under-



took their studies prior to the new law.

Hospitals that have conducted nonaccredited schools of nursing in this state, which are still nonaccredited, will find the new law lenient in behalf of their students. For the first time, each course is to be considered separately as a basis for the eligibility of its graduates for a license. This opportunity applies only to graduates of a two year course in a general, rather than a specialized, hospital.

As hospital superintendents, we carry the responsibility of scanning the credentials of all nurses who were graduated outside this state, particularly since there are generous provisions in the law for these nurses under certain classifications, if application is made by them before the period set by the law lapses.

For example, all of us in New York State are familiar with the bitterness and resentment of certain highly qualified graduate nurses from schools of nursing in other states over the clause of the old act of 1920 which debarred them from examination for a registered license here. Although such a nurse may have held a registered license from another state and have been graduated from a school of nursing accredited by the state in which it was located, she was still forced to do without a registered license here unless her school of nursing had been visited and accredited by the New York State Board of Nurse Examiners.

#### **Out-of-State Nurses Benefit**

To such a nurse, the new law offers an open door. For example, she not only becomes eligible for examination but under the qualifications just cited she may be relieved from the obligation to take it. She may obtain a New York license without examination, assuming that she meets the other requirements of age, residence, four years of high school or its equivalent, character and citizenship.

To other graduate nurses from out of the state who do not meet the residence requirement and whose schools of nursing have not been accredited by another state and who lack a license from another state, the new law is again more lenient than the

old act of 1920. The applicant becomes eligible to the examination heretofore closed to her. She has only to pass it to obtain a registered license. (Those out-of-state graduates who do not meet the residence clause of six months just prior to July 1, 1938 and whose schools are accredited in the home state but are not licensed in the home state may, until July 1, 1940, make application to try the New York State board examination.)

The penalty for any person holding a practical license who attempts to claim or to assume any other title has been mentioned. This penalty includes the revoking of her license, thus prohibiting employment. Equally severe measures are stipulated for the holder of the registered nurse license. If, through unprofessional conduct or habits, neglect of duty, the use of liquor or drugs, or mental illness such a nurse is declared unfit, her license may be revoked, again prohibiting the practice of nursing for hire. Thus, for the first time in New York State, the patient is protected from persons who should not be charged with the responsibility of caring for the sick.

It is only fair to add that physicians who sign affidavits for nurses as to character and ability may be called to appear before the state's investigating committee set up by the new law, if serious charges are made against the applicant as to violations or neglect of duty. In several cases, the new law requires a nurse to present affidavits from two members of a county medical society.

Passing mention has been made of the newly recognized practical nurse and her status under the law. As a matter of fact, the purpose of the practical license is to identify her, thereby keeping her strictly within the limitations of her training and ability. Above all, since the law makes it a misdemeanor to nurse for hire without a license, the requirement of a license from this secondary group brings them (and consequently, all unscrupulous self-styled "nurses" who fail to qualify) under the restraint of the law. The fine type of conscientious, mature woman who, in many communities throughout our state, has turned for self-support to practical nursing with-

in simple nursing and housekeeping routines will also be protected from competition by the imposter.

Now as to the practical license: if a practical nurse has been lawfully and reputably engaged in nursing for one year prior to July 1, 1938 and has two affidavits from physicians who vouch for her, she is eligible for a practical nursing examination by the state for a practical license. For her there are the requirements of citizenship, age and character, such as there are for the registered nurse.

If the practical nurse has been engaged in practice for five years within the last ten years, no examination is required. She gets her license if two physicians certify to her practice. If a certificate for a trained attendant is held, she may exchange it for a practical license. A nine months' course for a practical nurse will be required of all those who apply for a practical license after July 1, 1940. These nine months' courses were announced last fall.

#### **Licensing Orderlies**

An interesting by-product of the practical license is that it will be required of hospital orderlies performing nursing duties. At the last state hospital association meeting, this was discussed and agreed upon. It is my feeling that this will do much to elevate the standards for all orderlies who perform certain simple nursing duties for male patients. In not a few hospitals deplorably low standards in the selection of orderlies exist. Some orderlies who perform nursing duties would undoubtedly make acceptable male nurses, given an opportunity for adequate training; others, unfortunately, are more fitted for the street from which they drifted in.

The new law in no way seeks to enlarge or to expand the function of nursing. In fact, the law expressly prohibits "the treatment or cure of disease, pain, injury, deformity or physical condition, in violation of article 48 of the Education Law."

Three representatives of the state hospital association, along with representatives of the state medical society and others, will serve (as they do now) on the advisory committee to the department of education on the administration of the law.

# Views of 20 Leaders on Insurance for Indigents

CONSIDERABLE difference of opinion both on general principles and on details has been shown by hospital administrators, government officials, hospital care insurance executives and others who have expressed their ideas concerning the proposal made in the December issue to include indigents in hospital care insurance plans when these have been expanded to include medical service. (See "Insurance for Indigents," *The Modern Hospital*, December 1938, p. 47.)

On the basic principle of having a unified instead of a dual system of medical service, opposition is expressed by some prominent hospital executives and support, by others. Quotations will make this clear.

## Opponents of Idea

Dr. Peter D. Ward, administrator, Charles T. Miller Hospital, St. Paul, Minn., writes:

I am not altogether in agreement with you on a unified hospital and medical service for all. I do not concede that indigent patients should have the privilege of selecting either doctor or hospital. I believe that the manner in which this care is now given and controlled by private and governmental agencies is desirable and feel that they should be classified as two separate and distinct groups. In my opinion, indigents are receiving quite satisfactory medical and hospital care at the present time.

Much the same point of view is very well expressed by Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital, Boston.

In general I would favor the dual plan, in that it leaves a plan which is at present working rather satisfactorily as it is and adds another plan to cover groups in the community who are not adequately protected. To initiate this new plan will be considerable of a job and to include the indigent in it, supporting them from taxation funds and treating them as health insured individuals, will put a further strain upon the adjustment necessary. If, after both

systems are working smoothly, it seems wise to join them it would seem to me this would be much easier to accomplish than to try and start off with an all inclusive system.

I think it is just as well to set apart those people who are the recipients of charity from those who are self-supporting. I cannot accept the theory that the state owes everybody a living. I believe that the state owes everybody an opportunity in which they may produce their own living and that if they fail, then, the state should assist them. There should be some reward for the person who through his own efforts supports himself that will distinguish him and set him apart from the person who is state supported.

From Dr. Benjamin W. Black, medical director, Alameda County Hospital, Oakland, Calif., comes a somewhat different series of objections to the proposal.

The article assumes that indigent patients receive medical care which is inadequate or not comparable to that received by private patients. . . . I am quite sure that, while medical care for indigents is inadequate and incomplete in certain places, it is equally true to state that the care and treatment of indigents in many other places is equal in every respect to the care . . . received by private patients.

Your reference to the care of chronic patients in hospitals is pertinent owing to the fact that no insurance program involving either hospital or medical care does now provide for the care of chronic cases. Too little attention is given to the chronic.

There are so many difficulties, in addition to those mentioned in the article, that would need to be overcome that we should think in terms of fundamentals rather than some plan at the moment to make the care of indigents adaptable to that now being proposed for the large number of people in the higher income brackets. I agree fully with the statement that the unified coordinated medical service for all the people is in keeping with the American democratic tradition but until certain basic principles are adopted . . . it may not be expected that such a service can be accomplished.

Opposition to the proposed program is also offered by H. L. Lurie, executive director, Council of Jewish Federations and Welfare Funds, Inc., New York City. His statement is too long to quote here in full and it will appear in a future issue of the magazine. The essence of it may be stated to be a belief that the problem is so large that only governmental units are able to cope with it.

Speaking both as a hospital administrator and a public health official, Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston, considers the plan as impractical because "those responsible for tax funds could not possibly enter into insurance provision for the furnishing of medical care and hospitalization, since I can think of no way in which [they] . . . could possibly anticipate how many or whom of the population they should insure. So I take it that you would expect tax funds to reimburse for service actually rendered. This raises the question, therefore, whether reimbursing hospitals and doctors on the same basis and in the same amount as that paid for those who carry insurance . . . would be the most economic way. . . . It seems to me that in those communities where tax-supported hospitals and dispensaries exist it would seem logical and easy to interrelate with their activities the necessary domiciliary medical services for the poor."

## Public Health Viewpoint

Doctor Wilinsky also states that freedom of choice of practitioner and hospital will be more expensive than for the government to maintain care on a group or even an individual basis. "The individual who pays his insurance premium," he says, "will not want group practice." He strongly supports the idea that the care of the indigent, whether in government or voluntary institutions, is a responsibility of tax funds and that well-functioning tax-supported insti-



tutions should be used up to their capacity and then voluntary agencies utilized.

One correspondent, who prefers to remain anonymous, suggested that the various groups of "indigents" should be separately considered. The able-bodied person who is temporarily unemployed, for example, might perhaps be included in insurance plans that could not be applied to those receiving old age, blind, mothers' or other types of government pensions or relief.

#### **Regard Proposal as Promising**

Over against these objections to the proposal are a number of statements from persons who believe that the proposal is sound and promising. In a letter published last month, Dr. G. Harvey Agnew, president of the American Hospital Association, points out that a close parallel of the proposed plan has already been tried out in Ontario.

"Particularly important," Doctor Agnew says, "has been the vindication of the viewpoint that voluntary organizations can safely administer state funds." He points out, however, that the indigent might not be permitted quite the same latitude of choice of physician that is expected for the paying patient.

Dr. Claude W. Munger, director, St. Luke's Hospital, New York City, suggests a variation in the program.

The development of group payment plans for meeting the individual citizen's costs of prevention, care and treatment of illness is to my mind the only feasible solution of the great and pressing need to bring the full advantages of medical care to all of the population.

The proposal to arrange these plans so they will fit the needs and resources of various strata of the self-supporting and so that the government may pay part or all of the premiums for the indigent is by no means impractical. Through such a plan one can visualize a complete coverage of the population, offering all essentials to the indigent and providing nonessential luxuries to employed groups in accordance with the class of service provided by the premiums paid.

As I now see it, I would not advocate inclusion of medical fees for persons of the semiprivate or private room class. Inclusion of medical care to ward patients and exclusion of higher income groups from insuring in that class ought

to work definitely to the advantage of the doctor as compared with the present situation.

Traditional "group hospitalization" will not provide sufficiently broad benefits to safeguard the health of the population. A workable plan for adding domiciliary medical services and for hospital admission for diagnostic work only, when necessary, will need to be added.

From John R. Mannix, assistant director, University Hospitals of Cleveland, comes the following:

I am in agreement with the suggestion in the article entitled "Insurance for Indigents." The acceptance of hospital insurance plans by the American public during the last five years is ample evidence that such plans can and will meet the problem of budgeting for hospital care, even for the lowest income groups.

That the government must pay for hospital care to the indigent is generally accepted by all groups giving thought to the matter. However, this can best be done through voluntary hospital service plans. Such a method would make it unnecessary for the government to set up an extensive national organization and would, therefore, tend to keep cost at a point below that which would result if the government were to set up machinery of its own to handle this problem.

#### **From Welfare Field**

Approval of the general idea is expressed by several authorities in the welfare field. Fred Hoehler, director, American Public Welfare Association, suggests a partnership arrangement between the professional groups and the public.

A unified system is sound administratively and will be of greater profit to the client because the whole program of medical care can be handled in one move, avoiding the necessity of making several contacts. Savings in administrative costs would be material and, if a good plan can be worked out which is acceptable to the physicians and the hospitals with the principle of free choice preserved, I see no reason why it could not be established in most places where they will be considering medical care.

This will, of course, require an overhead organization working with both the hospital group and the physician group, which should provide some measures for controlling and preserving standards. I think such an overhead administrative body should be repre-

sentative not only of the two professional services concerned, but also of the general public—whatever that is.

Bleecker Marquette, executive secretary of the Public Health Federation of Cincinnati, also believes that an effort should be made to work out the problem along the lines proposed.

The rapid development of group hospitalization and the interest a number of local medical societies are now taking in medical service plans open up intriguing possibilities. This is certainly the time to be thinking about the integration of these two types of service so important to families of modest income.

This significant development also gives rise definitely to the question of the relation of these plans under unofficial auspices to proposals for government aid in taking care of the same needs for indigent families. The problem is not simple. Many difficulties will no doubt arise. . . . There is undoubted merit in one coordinated plan if it can be worked out.

#### **From Hospital Insurance Men**

R. F. Cahalane, executive director of Associated Hospital Service Corporation of Massachusetts, Boston, writes that the proposal "appears to me as fundamentally sound. . . . This business of medical care insurance seems to be rolling up like a prairie fire in a drought. It is ridiculous not to strike while the iron is hot to give the people what they need and want and keep government out of a job which many of us believe can be done satisfactorily in an American way, the voluntary way."

The director of another hospital care insurance plan, Felix A. Grisette of Chapel Hill, N. C., also writes in the same vein.

I have read your article, "Insurance for Indigents," in the current issue of *The Modern Hospital* and I agree entirely with what you say. It seems to me that the six reasons which you advance constitute excellent arguments in favor of a single, unified plan providing both medical and hospital services for people of a self-supporting type as well as those who are medically indigent. I should certainly regret to see the time when there would be two separate group payment plans in the same community for two different classes of people. Such an obvious public recognition of class distinctions would be abhorrent to those of us who still feel that the

*(Continued on page 130)*

# New Admission: The Camera

REINHARDT ROSENBERG

**P**HOTOGRAPHY is a valuable asset to the general hospital, and has all too frequently been neglected. In Chicago proper, to use just one example, out of 106 hospitals, only five or six have a photographic department. At least three of these hospitals are connected with medical schools and the photographic department serves both institutions.

In spite of this record there is a real need for photography in the general hospital. In institutions in which such work is done the photographic department is usually fully occupied. In addition to its regular work, it often is called upon to render services to staff members of other hospitals.

Photographs are a great help to almost every department in the hospital. They provide permanent and faithful records of the clinical appearance of patients. Pictures of accident victims may present valuable evidence in legal proceedings. Accompanying a case history, a series of photographs indicate the conditions and progress of the patient. Photographs are important as illustrations for an article, in the form of lantern slides when cases are presented at medical society meetings and for exhibits. They may even become of diagnostic help.

Medical men have recognized the importance of medical photography and proved their interest by their warm support of the biological photographic association. However, hospital management is often reluctant to make photographic facilities available because of the cost of maintenance, which is often considered to exceed the advantages. If a photographic department is organized in an efficient manner it will not cost a great deal.

For clinical photographs a camera is needed that takes negatives, 5 by 7 inches. This seems to be the most popular negative size as it is large enough to give good detail, yet it is

not so large that either equipment or materials are expensive. Such a camera, with an anastigmatic lens of sufficient speed and with a tripod, costs about \$80.

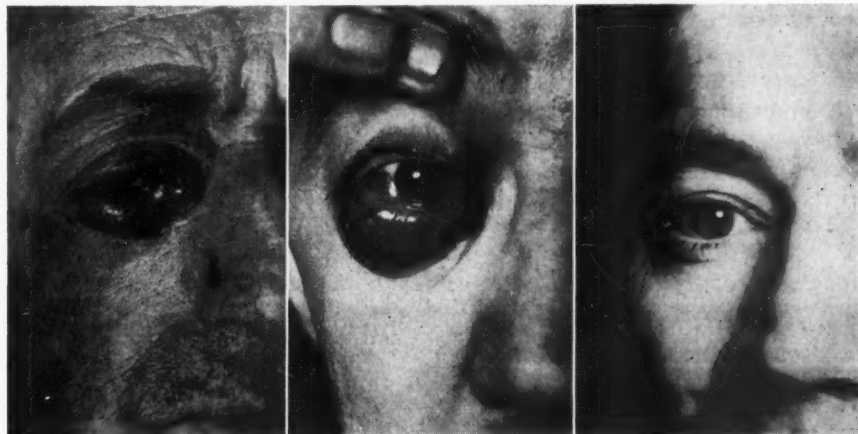
In order to obtain uniformly good results a background is essential. While a background can be bought for from \$5 to \$10, one is easily manufactured from a window shade of a flat black color on one side and a flat neutral gray on the other. Suspended from a suitable stand this will work admirably. Two double reflectors for lamps of the photoflood type, with stands, can be purchased for \$10. A photoflash reflector for \$2 completes a lighting equipment that will be adequate for almost every problem likely to be encountered in medical photography. Thus, for about \$100 a photographic unit has been purchased with which excellent medical pictures can be made.

Full length pictures of patients, close-up photos of superficial skin lesions, infra-red photographs, dental and intra-oral pictures, photographs of postmortems and of gross pathologic specimens, copies of charts and x-ray plates and many more types of photographic records of an excellent quality can be obtained with this equipment.

In order to reduce the cost of maintenance and to increase efficiency, a

dark room is essential. Its dimensions should be at least 8 by 16 feet and it should have cold running water. Any moderately sized table will serve as a work bench. The minimum of equipment consists of three enameled trays, 5 by 7 inches (\$0.45 each), a safelight lamp with at least three safelights (\$4.50) and a 5 by 7 inch printing frame (\$2). Thus a serviceable dark room can be equipped for about \$10. However, to widen the scope of the department, it is desirable to acquire an enlarger accommodating 5 by 7 inch negatives (\$30) and to replace the printing frame with an 8 by 10 inch printer of the table top type (\$35). With a scale, a few glass graduates and funnels, and some squeegee plates for glossy prints, the total will not exceed \$90.

No medical photographic department should be planned without the intention of buying either at once or in the not too distant future an apparatus for taking photomicrographs. This is of great importance, especially to the pathologist. It is the most expensive part of the equipment and for several reasons the cost is difficult to estimate. Various types and makes of equipment are on the market ranging in cost from \$15 to \$1500 and more. The price will be much lower if a microscope and optics are available exclusively for photographic use.



Tumor of eye on admission, at height of radiation reaction and on discharge.

The author is research associate in the school of medicine, department of anatomy, University of Pittsburgh.



No recommendations can be made, because the choice of apparatus depends on the requirements of the pathologist.

If only medium and high power photomicrographs for record pur-



**Infra-red photograph of the breasts. The dilated blood vessels in the left breast may mean cancer. Thus photos aid diagnosis.**

poses are required, an inexpensive camera will fill the order. If, however, low power pictures and a high quality are required for publication purposes, it is advisable to purchase more expensive apparatus. If the hospital has a machine shop at its disposal, it is possible to build a photomicrographic camera there. A good description of an inexpensive, adequate and adaptable photomicrographic camera will be found in the American Annual of Photography 1935, page 214, "The Technic of Photomicrography" by John King.

Thus the installation of a photographic service is not so expensive as is often supposed. Neither is the maintenance exorbitant. The material cost of one photograph and two copies is approximately \$0.20. If flashlights are used this is increased to \$0.35. The latter procedure is in most cases preferable in spite of its higher cost, because the quality is better and retakes are rarely necessary.

To assure quality of work and efficiency of service it is indispensable to have a competent and experienced biological photographer. No rules can be laid down regarding his salary. It is the result of an agreement between the parties concerned. He may work for a salary or for a small salary and commission. Part of his compensation may be in the form of room and board.

It should, however, be remembered that the photographer is a fully trained, skilled worker. If his salary

exceeds the hospital's budgetary allowance for its photographic service, arrangements may be made whereby the photographer works for several hospitals simultaneously. He would have to keep definite hours at each hospital so that appointments with patients can be made beforehand. With such an arrangement, only one dark room and one photomicrographic camera, located in one of the hospitals, would take care of several institutions.

While the services of a biological photographer are strongly recommended, he should not be the responsible head of the photographic department. Situations may be encountered in which it will be infinitely easier if a medical man is the director. This person is logically the pathologist. He is a member of the staff who is almost always at hand and who is much in need of a photographic department for photomicro-

#### Permission to Use Picture

*I hereby authorize the \_\_\_\_\_  
Hospital to use any picture of me in  
any way it may see fit, provided my  
name is not used in connection there-  
with.*

Dated \_\_\_\_\_ 19\_\_\_\_.

SIGNED \_\_\_\_\_

Address \_\_\_\_\_

graphs and gross pictures of cadavers. While the photographic department may be a part of the department of pathology, it should be located so that it is easily accessible to patients, whether they walk, move in a wheel chair or are brought on a cart.

When the photographer is requested to take a photograph he should be free to do so without the pathologist's confirmation of the order. A charge should be made for every photograph which will partly or fully carry the running expenses of the department and, at the same time, will keep requests for pictures on a reasonable level. Before a picture is taken, a form should be made out in duplicate giving the names of the doctor and of the patient, as well as the patient's record number. It should indicate the date on which the picture was taken, the diagnosis, the type and the location of the lesion.

Furthermore it should bear the signature of the photographer and a blank space for that of the attending physician. The physician signs upon receipt of the photograph, thereby acknowledging the charge. One print of the picture, attached to the negative, should be filed away by the photographer for future reference.

This is not the place to discuss the methods of making good photographs, but a few things may be pointed out that are of importance and of general interest.

When a photograph is made, it is a good policy to have the patient sign a release which authorizes the attending physician or the hospital to publish the picture in scientific articles. A good form of release is shown herewith. While it is not a legal contract, it has proved quite adequate. As an added precaution the face should be rendered unrecognizable. This is accomplished by giving the patient dark eye glasses. They conceal his identity and also give good protection against the strong lights used as a source of illumination. If pictures are made of lesions that are so located that eye glasses cannot be worn, the picture should show only a portion of the face.

When pictures of female patients are taken, it should be an inviolable rule that a nurse be present who can testify for the photographer, should this become necessary. This is, of course, unnecessary if the patient does not have to undress or if the photographer is a woman.

The illustrations on the preceding page were chosen to demonstrate some of the services which photography may give a department devoted to the treatment of cancer.

The first photograph of the patient was made upon admission before any treatment had been administered and before a biopsy had been performed. Since radium therapy was employed, the patient was photographed again when the radiation reaction was at its height. The third picture was made before the patient was temporarily dismissed, after completion of treatment and subsidence of the radiation reaction. Thereafter, additional pictures were taken from time to time when the patient came for a "follow-up" examination, thus producing a complete pictorial history.

## Working With Your Neighbors

CHARLES H. SCHWEPPE

THE trusteeship of a voluntary hospital is becoming an increasingly important responsibility in the community. This is due primarily to the fact that the voluntary hospital is coming to occupy a tremendously important position in the new health and hospitalization programs that are being developed in response to the recent mass interest of the public in matters of health and social welfare.

Perhaps I should say at once that I believe it to be a proper function as well as a responsibility of the voluntary hospital to assume leadership of the public health program as it applies to matters of hospitalization. It is the continual reemphasis of this point of view which will keep the voluntary hospital from being looked upon as some outdated relic of private benefaction and which will provide it with an objective consistent with the spirit of the times. As Dr. Selim W. McArthur, chief of staff of St. Luke's Hospital, Chicago, said recently: "The voluntary hospital is run solely for the benefit of the community at large. It is not run for the benefit of the group of trustees, the administration or even the medical staff. These are merely integral parts of the hospital."

### Isolation Does Not Pay

If the voluntary hospital is to be held responsible for adequate community hospital service, then those responsible for the management, policy and administration of such an institution had best look not only to the hospitalization needs of the community but to the resources and facilities of hospitals individually and collectively. Furthermore, I doubt whether any hospital today, isolated from its sister organizations in a community, can fully understand or

appreciate its social problems or purposes unless it resolves to work in close cooperation with its neighbor hospitals and allied institutions.

In this connection I should like to quote from a recent editorial published in the Chicago Hospital Council Bulletin: "Hospitalization and its attendant problems belong primarily and rightfully to the hospital and to all those who are responsible for its management, policies and administration . . . but no individual voluntary hospital in the metropolitan area is today capable of meeting the community's hospital needs singly and alone."

### Central Organization Works

"This is due at least in part to the fact that the problem of adequate hospitalization has come to involve ramifications into social, professional and economic fields beyond the province of the individual hospital as such. The problem of group hospitalization is an outstanding example of this fact; . . . an effective organization truly representing hospitals is therefore essential in dealing with the many problems incident to adequate community hospital service."

Just as it is becoming increasingly important that trustees become more and more familiar with the social and community responsibilities of their respective hospitals, so it is becoming increasingly desirable that these trustees become better acquainted with one another's hospital problems through some central organization, for it is through such a local organization that they will learn and understand their mutual problems, procedures and objectives. One of the best ways in which to do this is through the type of organization now generally known as a hospital council, which is made up of

hospital administrators, trustees and staff members.

Realizing that metropolitan areas such as New York, Boston, Cleveland, St. Louis, Minneapolis and Chicago have long ago outgrown the traditional idea that hospitals are isolated independent houses of mercy with no necessary connection with one another or the community generally and are therefore increasingly in need of coordinated effort in hospital affairs, a group of us in Chicago convened in the summer of 1935 to consider ways and means of establishing an organization that could serve adequately both the community and its hospitals in meeting the manifold problems incident to efficient hospital and out-patient department care.

The result of this and subsequent meetings was the organization of the Chicago Hospital Council, which has carried on successfully since that time and now includes in its membership practically every important approved hospital in Chicago and its environs. This organization still has a large task ahead but it has in these first three years fulfilled our most ardent original anticipations, particularly in regard to interhospital cooperation in all major problems confronting hospitals in this community.

### Council Accomplishments

Among its present accomplishments may be listed such major studies as the one on hospitalization insurance, which led to the formation of our Hospital Service Corporation; the study, under the chairmanship of Dr. Arthur C. Bachmeyer, relating to personnel practices, wages, hours, perquisites and the like; the study, under the chairmanship of Dr. Fred L. Adair, relating to the facilities of and practices in maternity services; the study,

The author is president of St. Luke's Hospital, Chicago, and of the Chicago Hospital Council.



under the chairmanship of Dr. Malcolm T. MacEachern, relating to public emergency ambulance facilities, and the study, under the chairmanship of W. P. Slover, on hospital service rates.

There are many other investigations which the council is continually required to make, such as those in the fields of central purchasing, credits and collections, legislation, comparative occupancy statistics, comparative statistics on hospital income and expense by departments, comparative costs of services rendered to patients and air conditioning.

In smaller communities in which there are only two or three hospitals, it is not feasible to organize formally

a hospital council with a central headquarters and a full-time staff. In such instances I would, of course, urge the administrators, trustees and staff members of these hospitals to form a local association that will allow these persons to become better acquainted with one another through regular meetings at which time mutual problems may be discussed and policies established. I cannot urge too strongly some arrangement, however informal, that will allow for the easy exchange of information, opinions and policies relative to neighbor hospitals in the same locality.

Trusteeship of a voluntary hospital is today something more than an amateur's delight in a temporary avocation. It is a real privilege and

a serious responsibility: a privilege to serve where unselfish service and charitable enterprise are really needed, and a responsibility to the community in which the problems of health and hospitalization have come to occupy a place of outstanding importance.

These problems we can expect to have always with us. Our solutions must, therefore, be worked out on a permanent basis. This can be done only if the trustees of all approved voluntary hospitals in a community will cooperate in working out not only the special and specific problems confronting their individual hospitals but the more general health and hospitalization problems confronting the community at large.

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## Dividing Line Is Drawn

**W**HAT should be the relationship between trustees and hospital personnel? Those trustees who attended the last meeting of the American Hospital Association approved the following principles at the special section meeting devoted to trustee problems:

1. The board of trustees has complete authority over and responsibility for the conduct of the hospital. It represents the liaison body between a community utility and its contributing supporters.

2. The chief function of the board of trustees is to be responsible for the efficiency in the purchase of hospital service with the community's dollar. It is a policy-making and not an administrative body.

3. It is the duty of the board of trustees to obtain a well-trained administrator of the hospital, refusing to accept for such a position any applicant who is not qualified professionally, ethically or morally.

4. It is the duty of the board of trustees to require that well-trained and ethical department heads are obtained but the actual selection of, and negotiation with, these department heads should be the duty of the administrator.

5. The arrangement of service, the application of discipline and the

maintenance of the morale of all members of the hospital personnel are not functions of the board of trustees but fall in the administrative duties of the executive of the hospital.

6. No official contact should be made between the board members and department heads or their subordinates without the presence of the administrator or his representative.

7. It is not ethical for department heads or other subordinates officially to contact board members without the presence of the administrator or his representative.

8. It is wholly necessary that the administrator be invited to attend the regular meetings of the board.

9. Lay groups or individuals officially or unofficially attached to the hospitals should not be permitted to make rounds and contact patients or personnel without the presence or the permission of the administrator or his representative.

10. Generally it may be said that no matters of business should enter the hospital except by way of the administrator's office and by the same token it may be said that no matters concerning the conduct of the hospital shall go therefrom except over the administrator's desk.

11. It is strongly recommended that the board of trustees make pos-

sible the attendance of its executive at local, state and national hospital meetings and also urge department heads to attend such meetings. A report of the high points of such meetings should be brought to the board of trustees.

12. It is urged that boards of trustees take steps to encourage their members to acquaint themselves with hospital problems and to participate to the greatest extent possible in local, state and national hospital meetings.

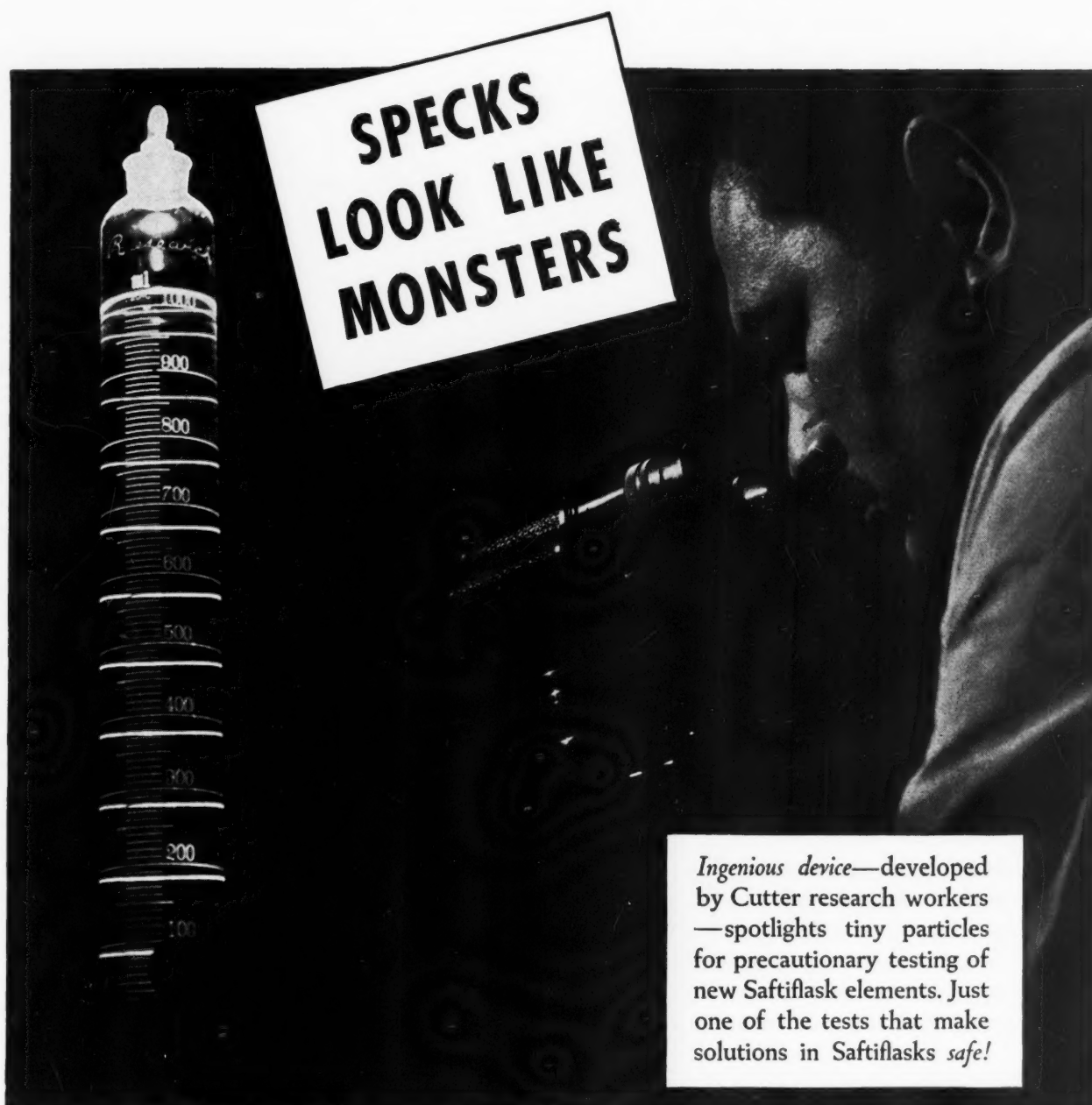
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### Value of Doctor-Trustee

Physicians as a group have gradually allowed the business man to play an increasing rôle in hospital management, declared Dr. Arthur W. Elting, former president of the American Surgical Association, in a recent address before this association.

There is an increasing tendency for government to enlarge its contributions to hospital support, Doctor Elting asserted, and with this will come an increased participation of government officials both in the duties of the lay group and of the professional group.

The best method to prevent government infiltration into hospital management is for the professional group to take a greater interest and to play a more active part, Doctor Elting told his colleagues.



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## Inhalational Therapy Equipment

MORRIS ECKMAN, and ALVAN L. BARACH, M.D.

THE last ten years have witnessed a considerable growth in the field of inhalational therapy. Oxygen is now being used in the treatment of congestive heart failure, acute coronary thrombosis, pneumonia, emphysema and other diseases of impaired lung function. The use of helium and of various vaporized substances, such as epinephrine and neosynephrin, in obstructive respiration is a new development in this field.

With this growth in the use of oxygen, helium and other inhalants there has been a corresponding development of different types of apparatus until it has become imperative that trained personnel be delegated to supervise the care and operation of inhalational therapy equipment.

In many hospitals it is the practice to call an orderly or some other un-

trained person to set up tents and nasal catheters. Frequently the equipment in use is in poor repair and the administration of the therapeutic gas is carried out in a slipshod manner. Fully 90 per cent of the oxygen tents in institutions throughout the country are not equipped with testing devices to determine the oxygen concentration of the gas administered; in a considerable portion of the other 10 per cent there is no one available in the hospital who knows how to make the test.

We believe it would be of help to set down in detail the technical procedure about which the personnel in charge of inhalational therapy should be thoroughly informed.

In the main, we have described procedures in use at the Presbyterian Hospital, New York.

valve *F* by means of nut *D* and tighten with a wrench.

3. Remove handle *C* from the reducing valve (counterclockwise) and open tank valve *F* very slowly. The contents of the tank will register on gauge *A*.

4. Replace handle *C* in the valve body and turn clockwise to obtain the flow of oxygen desired. The rate of flow will register on gauge *B*.

5. Connect to threaded outlet *E* either a nipple, a water bottle or an injector depending on the type of apparatus to be used.

### Precautions

1. Never use oil on any part of an oxygen gauge or a tank.

2. Always remove handle *C* from the reducing valve before turning on the tank.

3. Use the tank until it empties.

4. If the contents gauge *A* is not calibrated in liters, multiply the pressure reading by 3 to determine the number of liters of gas in the cylinder.

## Technic of Oxygen Therapy

### Reducing Valves and Tanks

**Description:** The reducing valve (fig. 1) has two gauges: a contents gauge *A*, calibrated in pounds' pressure or liters, or both, and a flow gauge *B*, calibrated in liters per minute. Flows from the valve are controlled by the valve handle *C*. The nut *D* is used to connect the reducing valve to the oxygen tank valve *F*. To the threaded outlet *E* may be connected either an ordinary nipple (fig. 1), a water bottle for catheter use (fig. 2) or an air injector for mask use (fig. 4).

#### Directions for Use

1. "Crack" the oxygen tank by opening tank valve *F* (counterclock-

Mr. Eckman is assistant to Doctor Barach in the department of medicine, College of Physicians and Surgeons.

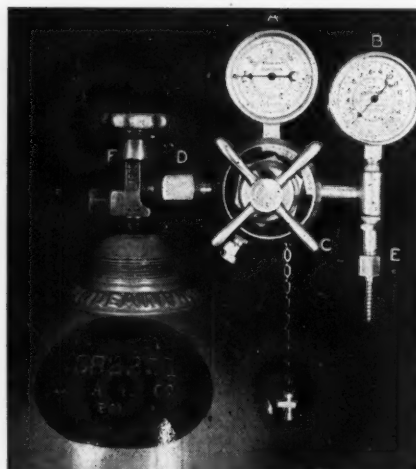


Fig. 1—Reducing valve.

wise) very slightly until a hiss of escaping gas is heard. This is done to blow out any dust that might have collected in the nozzle of the tank valve.

2. Attach a reducing valve to tank

### Nasal Catheter

**Description:** The nasal catheter outfit (fig. 2) consists of a reducing valve with water bottle attached, 5 feet of rubber tubing, a metal adaptor and a No. 10 or 12 French catheter. If a "Y" is substituted for the metal adaptor two catheters may be used. The catheter should be perforated within its terminal inch by six or eight small holes.

#### Directions for Use

1. Lubricate the end of the catheter with a soluble jelly and insert it along the floor of the nasopharynx until the tip of the catheter touches the posterior wall of the nasopharynx. Withdraw the catheter  $\frac{1}{4}$  inch. The correct position of the catheter when

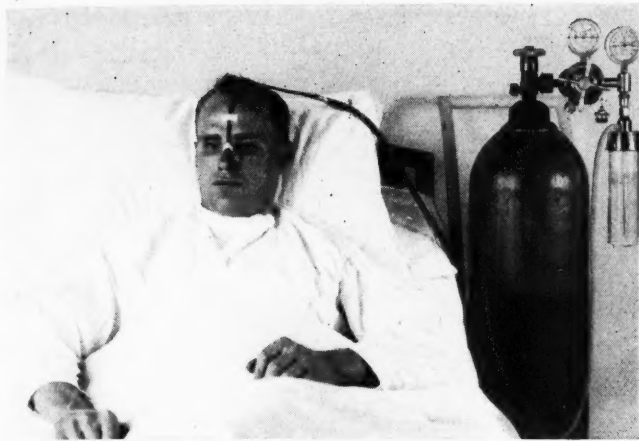


Fig. 2—Nasal catheter outfit taped securely to the nose.

using this method is shown in figure 3, point A.

2. Bend the catheter along the bridge of the nose or along the side of the face and over the ear and tape it securely in two places. Attach the catheter to the metal adaptor, the adaptor to the rubber tube, and the rubber tube to the water bottle.

3. Turn on the oxygen to the flow desired.

#### Precautions

1. The water bottle should be kept from one-half to two-thirds full of ordinary tap water at all times. Water may be added by unscrewing the glass part of the water bottle from the metal cap.

2. Catheters should be removed four times daily for boiling and cleaning. If a single catheter is used, use the alternate nostril when reinserting.

3. A flow of 4 liters per minute will yield approximately 32 per cent of oxygen in the inspired air. Should higher percentages be desired, administer from 6 to 8 liters per minute, which will yield from 36 to 40 per cent of oxygen. To prevent undue irritation to the nasal mucosa with higher flows, use the double catheter.

### Oropharyngeal Catheter

**Description:** Same as the nasal catheter except that a No. 8 or 10 French catheter is used.

#### Directions for Use

1. Turn on the oxygen, lubricate the catheter and insert it through one nostril down the posterior wall of the pharynx to a point opposite the uvula.

2. Tape the catheter to the nose or the cheek.

3. Regulate the flow of gas.

#### Precautions

1. If the patient swallows a bolus of air in the act of deglutition the catheter is inserted too far. Withdraw the tip of the catheter to a point where no gas is swallowed during deglutition. Viewed through the mouth this point is usually about level with the tip of the uvula as it hangs quiescent during nasal breathing (fig. 3, point B).

2. A flow of 4 liters will yield approximately 41 per cent of oxygen in the inspired air; 6 liters, approximately 47 per cent.

3. For other precautions, see 1 and 2 under nasal catheter precautions.

### Face Mask

**Description:** The face mask outfit (fig. 4) consists of a reducing valve with an injector attached, 5 feet of  $\frac{3}{8}$  inch (inside diameter) tubing, a glass adaptor with at least a  $\frac{1}{4}$  inch bore and a mask.

#### Directions for Use

1. Fit the mask snugly across the bridge of the nose at the top and along the edge of the lower jaw at the bottom. The pliable metal edge at the top of the mask may be bent to conform to the contours of the face.

2. Bend the metal ear pieces around the ears of the patient to hold the mask securely. Attach the mask to the adaptor and tubing as shown in figure 4.

3. Run oxygen at a flow of from 6 to 12 liters per minute. This will

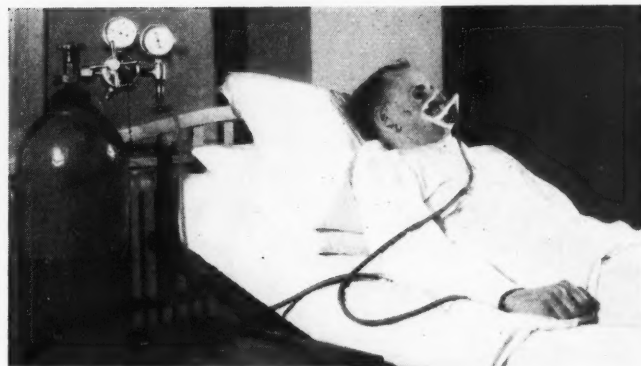


Fig. 4—Face mask outfit.

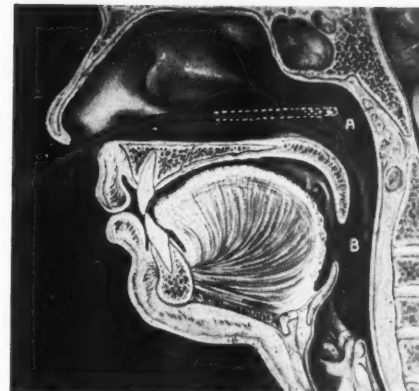


Fig. 3—Oropharyngeal catheter.

provide an oxygen concentration in the inspired air of approximately 40 to 55 per cent.

#### Precautions

1. The mask should be used with an air injector to prevent excess accumulation of  $\text{CO}_2$  and moisture, especially at the lower flows.

2. The  $\frac{3}{8}$  inch (inside diameter) tubing and  $\frac{1}{4}$  inch bore adaptor must be used to ensure proper functioning of the air injector.

3. The hole in the red rubber tubing within the mask must be placed exactly beneath the nostrils so that the oxygen entering the mask will be directed upward into the nose.

4. Percentages of oxygen in the inspired air at various flows are as follows: 6 liters per minute, 42 per cent; 8 liters per minute, 46 per cent; 10 liters per minute, 50 per cent; 12 liters per minute, 53 per cent.

5. If the tubing leading to the mask is kinked in any way the whistle on the rear of the air injector will sound. Straighten the tubing to ensure proper functioning of the mask so that the patient will obtain full benefit of the oxygen.

6. Do not use a water bottle, as the moisture in the patient's expired air increases the relative humidity of the inspired oxygen.



## Inhaler

**Description:** The inhaler outfit (fig. 5) consists of a reducing gauge with ordinary nipple, 5 feet of tubing and the inhaler.

### Directions for Use

1. Strap the inhaler to the forehead as shown in figure 5.
2. Attach the rubber tubing and turn on the reducing valve to from 6 to 12 liters per minute.

### Precautions

1. Use an ordinary nipple on the valve. Never use a water bottle as it causes moisture to accumulate in the nose cap.
2. Strap the inhaler securely so that the gas inlets are about  $\frac{1}{8}$  inch below the edge of the nostrils.
3. The percentages of oxygen in the inspired air with various flows are slightly higher (1 to 2 per cent) than those with the face mask.

## Oxygen Tent

**Description:** The oxygen tent we use consists of a motor driven air conditioner and a hood. The door on the top of the air conditioner cabinet covers two ice compartments. Below the ice compartments is a motor driven blower for circulation of air. On the front of the conditioner cabinet are found the motor plug, switch and pilot light plate, the water drain and the rheostat for controlling the temperature of the gases in the hood. On the support tubes are connected the thermometer and

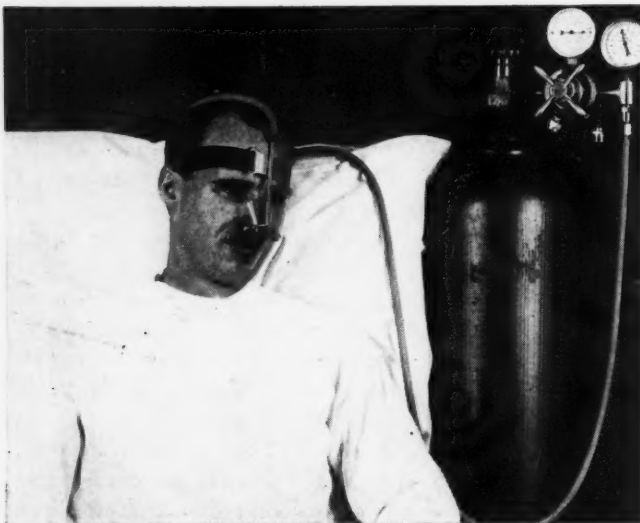


Fig. 5—Inhaler.

the gas inlets. The hood is made of either pliofilm, a light transparent rubber fabric, or of rubberized cloth with plastocel windows. Plioilm is to be preferred.

The following directions apply only to motor driven tents.

### Directions for Use

1. Fill both ice compartments with large chunks of ice.
2. Wheel the tent to the side of the bed or behind the bed and tuck the hood under the mattress around the front, sides and rear.
3. Attach the motor plug to the wall plug with the electric cord. The pilot light will glow when the motor is turned on.
4. Open the water drain and adjust the rheostat to midposition.
5. Attach the oxygen tank and the reducing valve with an ordinary nipple to either one of the gas inlets.
6. Run the oxygen at 14 liters per minute for thirty-five minutes and then turn the flow down to 10 liters.

### Precautions

1. The ice compartments should be filled whenever the supply is low.
2. The water drain must be kept open at all times while the tent is in use.
3. Keep the hood tucked firmly under the mattress to prevent leakage.
4. Check the oxygen tank frequently and change the tank as soon as it empties.
5. Overheating of the tent may be caused by any or all of the following: electric cord disconnected from wall or conditioner cabinet, motor switch turned off, insufficient ice in ice compartment, water drain shut off and rheostat not adjusted properly for sufficient circulation. To make the tent cooler, move the rheostat pointer toward the "cold" or "fast" side.
6. Lack of oxygen in the hood may be caused by one or more of the following: insufficient flow of oxygen from the tank, hood not tucked in properly, ice compartment door open, leaks in air circuit or careless

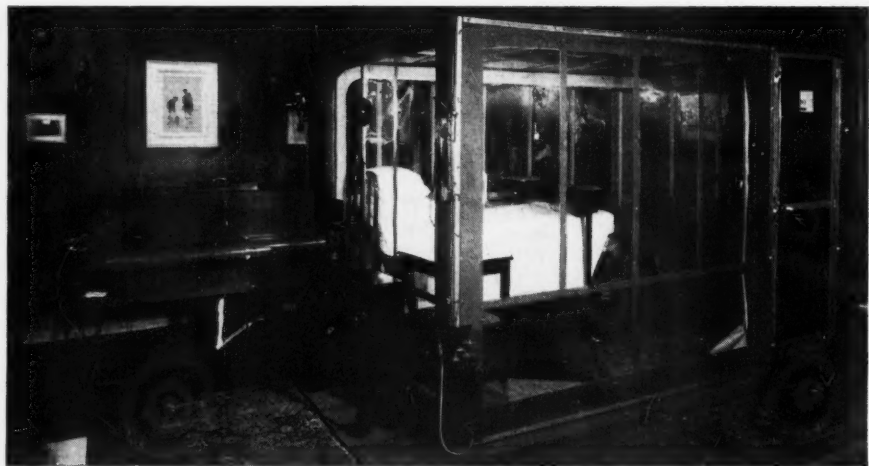


Fig. 6—The portable oxygen room.

7. Test oxygen at frequent intervals to ensure proper concentration in tent. If concentration is too low, run in gas at 14 liters per minute. With this flow, the concentration of oxygen will rise at the rate of approximately 1 per cent per minute.

8. Should the hood be torn, patch it with adhesive tape.

9. To sterilize the hood at the termination of treatment: (a) for pliofilm canopies, use 70 per cent alcohol; (b) for heavy green cloth canopies, use 70 per cent alcohol on the cloth and soap and water on the

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windows (alcohol clouds the windows); (c) when the tent has been used on a patient with pulmonary tuberculosis wash the hood with bichloride of mercury.

### Portable Oxygen Room

**Description:** The portable oxygen room (fig. 6) is essentially the same as the oxygen tent except for size. The room is constructed of rubberized fabric stretched over a collapsible metal frame. A large motor blower fitted with a rheostat draws the air from the room, passes it through the air conditioner and then back into the room. The door is gasketed with sponge rubber. Behind the door hangs a rubberized curtain to prevent leakage when someone enters or leaves.

Oxygen is admitted through two openings in one of the walls; one of the openings is used for rapid flow of oxygen in filling the room, the other for the normal flow. Another opening is provided for release of excess gas when filling the room.

#### Directions for Use

1. Fill the air conditioner with ice and turn on the motor.
2. Shut the door of the room, open the gas release valve and run in two tanks of oxygen as rapidly as possible. This quantity will raise the oxygen concentration to approximately 50 per cent.
3. Close the gas release valve and throttle the flow of oxygen into the room to 10 or 14 liters per minute.
4. Regulate the temperature by varying the speed of the motor blower by means of the rheostat.

#### Precautions

1. Fill the air conditioner with cracked ice (large pieces about the size of two fists) every eight hours.
2. In entering or leaving the room be sure that the curtain behind the door is not drawn to one side while the door is open.
3. Test the oxygen at frequent intervals.
4. Keep any electrical appliance or anything that might give rise to sparks out of the room. The door to the chamber should be marked with a warning sign regarding the danger of fire as a safety measure.

## Technic of Helium Therapy

### Helium-Oxygen Pressure Apparatus

**Description:** The helium-oxygen pressure apparatus consists of a conditioning cabinet and a hood with removable collar. The conditioning cabinet contains two shell natron CO<sub>2</sub> absorbers, *A* (fig. 7), a motor blower, *B* (fig. 7), motor switch and pilot light, *C* (fig. 8), and a rheostat for controlling temperature, *D* (fig. 8). The hood is

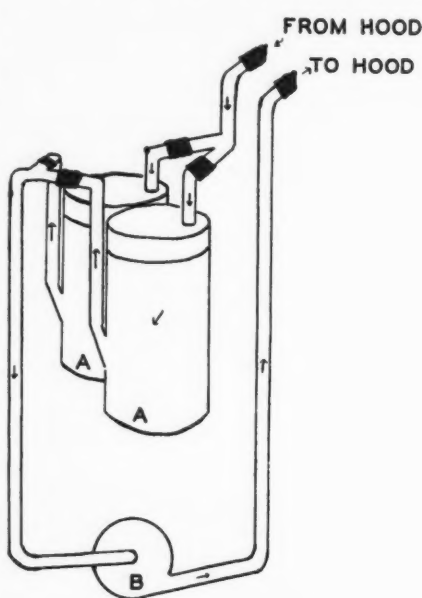


Fig. 7.

attached to the conditioning cabinet by means of two lengths of 1 inch (inside diameter) rubber tubing. To the hood is attached a pressure control water valve, *E* (fig. 8).

There is provided with the apparatus a reducing gauge with a calibrated water bottle for the helium-oxygen mixture tank, and a needle valve for flushing the apparatus with oxygen. These are connected to the conditioning cabinet by means of a Y tube and rubber tubing.

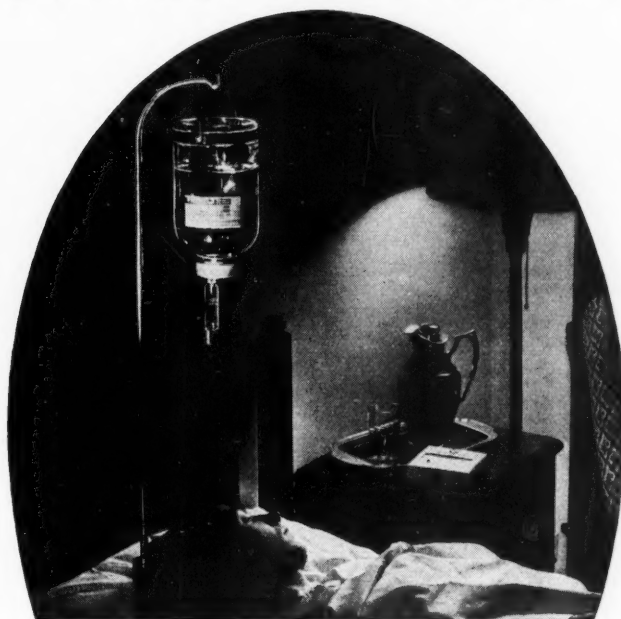
#### Directions for Use

1. Fill both shell natron CO<sub>2</sub> absorbers with shell natron. Screw the lids down tightly and lower them into the ice compartment, clamping them so that they will not float.
2. Fill the ice compartment with cracked ice and add sufficient water to keep the shell natron cans completely submerged.
3. Attach the hood to the conditioning cabinet by means of the 1 inch (inside diameter) rubber tubing.
4. Adjust the collar on the hood so that the neck opening is nearest the bottom of the collar ring. Fix the collar to the ring by means of the heavy rubber band provided.
5. Plug the apparatus into a socket and turn the motor switch to "on" position. The pilot light will glow. Place a small pillow in the hood and



Fig. 8—Helium-oxygen pressure apparatus.

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adjust the hood over the patient's head and neck. Tie the hood to the bed spring with straps provided for this purpose.

6. Open one sleeve of the hood and rapidly run 450 liters of oxygen (150 pounds' pressure) from the oxygen tank through the needle valve into the gas inlet to wash out the air from the gas circuit. When this quantity of oxygen has run in, start the helium-oxygen mixture flowing at 14 liters per minute and then shut off the oxygen.

7. Run the helium-oxygen mixture at the aforementioned flow for twenty minutes to bring the concentration in the hood down to the tank mixture. Close the sleeve of the hood and reduce the helium-oxygen flow to 2 to 3 liters per minute.

8. Attach the pressure control water valve to the hood and submerge the bottom of the pressure tube to a depth equal to the pressure desired.

9. Adjust the rheostat to give the cooling desired.

#### Precautions

1. Change one can of the CO<sub>2</sub> absorbent every twelve hours, alternating cans when doing so. It is unnecessary to interrupt the treatment to carry out this procedure. By using large hemostats to clamp the rubber joints leading to and from a single can, the can may be removed without causing any leaks in the circuit.

The following should be remembered: (a) if the shell natron is caked it may be loosened with water (dry the can thoroughly before adding fresh absorbent); (b) use gloves in handling the absorbent and do not allow it to come in contact with the clothing; (c) to prevent leakage, tighten the nuts on the can lids with a wrench before replacing the can in the circuit; (d) in replacing the can, attach the rubber joints to the arms of the can before removing the clamps.

2. Fill the ice cabinet with ice every five hours. Run off sufficient water to make room for the ice but see to it that the cans are submerged in the ice water at all times.

3. If the pressure control valve is not bubbling on expiration, a leak is present. Leaks are usually found around the collar or at the shell natron can lids.

4. If the hood is to be opened for any reason, run the helium-oxygen mixture into the circuit at 14 liters per minute. This is done to prevent inward leaks of air.

5. Test gas concentration for oxygen and CO<sub>2</sub> five times daily.

6. When running the apparatus at from 2 to 3 liters of helium-oxygen

per minute, the concentration of the oxygen in circuit will be from 4 to 6 per cent lower than in the tank mixture. Use a tank mixture 4 to 6 per cent higher in oxygen than the quantity desired for the patient or add 200 to 300 cc. of 100 per cent oxygen per minute in addition to the normal flow of the helium-oxygen mixture.

## Technic of Vaporized Solutions

### Nebulizer Set

**Description:** The nebulizer set for the administration of vaporized solutions of adrenalin and neosynephrin (fig. 9) consists of a glass nebulizer, 5 feet of rubber tubing, an oxygen reducing flow valve or a small centrifugal pressure blower.

#### Directions for Use

1. Place the solution to be vaporized and inhaled in the nebulizer by way of the wide opening.
2. Attach the nebulizer to the oxygen gauge with the rubber tube as

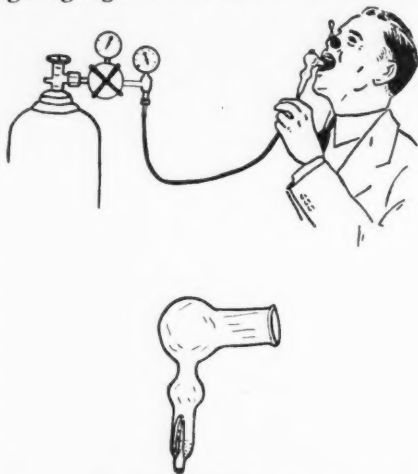


Fig. 9—Nebulizer set.

shown in the accompanying diagram and run the gas at the rate of from 6 to 10 liters per minute, depending upon the speed of vaporization desired.

3. Clamp the patient's nose and direct the wide opening of the nebulizer back into the mouth. Have the patient breathe through his mouth.

#### Precautions

1. Rinse the nebulizer thoroughly with water after use to prevent clogging.
2. If the nebulizer clogs, soak in

a cleaning solution for twenty-four hours and force a strong stream of gas through to dislodge the debris

### Buying Equipment

Scientific equipment has become so highly specialized that most hospitals have an equipment committee to pass on the merits of the various equipment asked for by the different departments, and it, in turn, makes recommendations to the board of governors.

This observation is made by the committee on construction and equipment of the Canadian Hospital Council.

Advantages of this procedure are: (1) a small committee can be better controlled in the matter of expenditure than each department; (2) enthusiasms for particular types of equipment may be controlled, and (3) newer types of apparatus may be thoroughly investigated before money is spent.

In the purchase of equipment, the most important factor is to get the equipment that will be most satisfactory to those who are to use it. Manufacturers of scientific equipment are quite prepared to put their equipment in new hospital buildings for a several months' test under actual working conditions. For instance, a highly important item is operating room lighting. It is only by trying out these various lights under actual working conditions that the surgeons can establish which is the most satisfactory of the many makes that are being continually put on the market.

Too much time cannot be spent on preliminary study before any decision is made; in the long run, it probably will save a great deal of grief and criticism from the staff.



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hol will do. That's why, in most cases, in most hospitals, U.S.I. alcohol is the choice.

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## Work With a Personal Touch

FLORENCE STOREY

**T**WO important functions of the housekeeping department are: (1) to keep the buildings clean and in order at all times and (2) to control the linen supply. These duties are of primary importance to the comfort and well-being of the patients. In addition, the reputation and prestige of the hospital depend largely on its appearance. An institution that is bright, shining and immaculate is sure to make a pleasant and lasting impression on the patients and the visiting community.

Every square inch of the building can be ready at all times for inspection, if the housekeeper will spend some time working out a routine with the housekeeping personnel and will strive to gain full cooperation. This will result in less waste of material and a feeling of greater personal responsibility among the employees.

### Keeping Down Cost of Supplies

At the Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill., we stress adequate use of materials for good results, but we deplore waste, even in small amounts. A record is kept of the amounts of material used in each department, and at the end of the month the department housekeepers and janitors are informed as to the total amount of each article used. Thus they learn who was extravagant and who was careful. There is a friendly rivalry among them as to who can get the best results with the least material used, such as wax, scouring powder and soap.

The selection of personnel for this department is most important. I find that I can take women of mature age who have been accustomed to good homes and can train them to give greater satisfaction than can so-called trained institutional workers. This

type of person has been available since the depression. These women have had their own homes and have loved them and I impress upon them from the first that the sanitarium is to be their home and should be taken care of as such. Instead of classifying them as maids, they are called department housekeepers. The title "maid" is irritating to women of this type. As a result of this attitude on our part, they really do take greater pride in their departments.

This situation applies to a greater or less extent among the men. Not one janitor employed here was ever a janitor before. In fact, the backgrounds of many of our domestic employees would make a fascinating story. For instance, we have a school teacher, a railroad man, a printer, a transcontinental bus driver, and several farmers among our workers. The men are given to understand that the department assigned to them is theirs and, after they have learned the routine, it is a great satisfaction to see them assume complete responsibility. Again, this is the result of being fortunate enough to find a higher type man than the average janitor.

All sanitarium domestic employees are paid fair wages, and all have an opportunity to earn more through length of service or advancement. For example, our first cook started as a department housekeeper. We found she was an excellent cook, gave her a chance in the kitchen as third cook, and, in less than two years, she was in charge of the kitchen with her original salary more than doubled. This same thing has happened in the case of several employees.

Employees are given a two weeks' vacation with pay each year, and sick leave is granted according to

length of service. The women are on eight hour duty, six days a week; the men's time figures out to six days a week, but their time off is given in half days. They average eight half days in a four week month. At present male employees are not on eight hour duty; they work from 6 a.m. to 6 p.m., with one hour off each afternoon and one-half hour for meals.

It is a part of my job to employ all domestic help. However, they understand that if for any reason they are to be dismissed, they will be given an opportunity to plead their case before the medical director and superintendent, who then takes it up with me. In this way, a greater sense of security exists among them.

All employees are x-rayed every six months. Wassermann and sedimentation tests are made and their general physical health is checked up at the time they are engaged. We do not give medical care to our employees. They are given first aid and sent to their family physicians. We carry workmen's compensation insurance for accidents while on duty and we urge all employees to carry hospital service insurance.

### Turnover Low, Morale High

Our oldest domestic employee, in years of service, has been with us nine years; the newest, one year. The morale is high and their willingness to serve is a joy to behold. Several of our old employees have been offered their former positions back, positions that pay a better salary than we can afford to pay. It is gratifying to hear them say that they prefer to remain here, as they explain that they have a greater feeling of security in working at the sanitarium and that with full maintenance, in addition to their salary, they are far better off in the long run.

The entire housekeeping personnel understands that it has free ac-

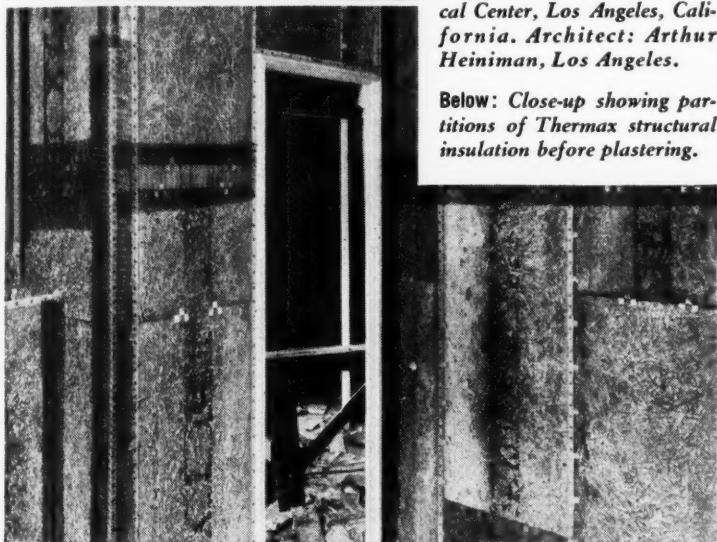
# RESISTS FIRE . . . CONFINES SOUND . . .

... CHOSEN BY  
LOS ANGELES MEDICAL CENTER  
TO *Safeguard Patients*



Above: New Los Angeles Medical Center, Los Angeles, California. Architect: Arthur Heiniman, Los Angeles.

Below: Close-up showing partitions of Thermax structural insulation before plastering.



NOWHERE is quiet more important—nowhere are casual sounds more difficult to isolate—than in the average hospital. Footsteps, voices, the clatter of trays or the undertone of a nearby radio—all are disturbing to the patient who needs quiet—all are handicaps to recovery!

Unwanted sounds *can* be controlled. In the new Los Angeles Medical Center, sound is confined and each room made a haven of quiet by the use of Thermax structural insulation in partitions. This material, *used as a plaster base*, has high sound-insulating efficiency. At the same time, it contributes fire-resistance and structural strength!

The large rigid slabs of Thermax insulation are equally well suited for partitions, ceilings, roof decks, or furring—make an ideal base for plaster or stucco. Made of clean shredded fibres coated and bound with fire-resistant cement, this material is widely used in fireproof construction, and is approved by building departments of leading cities in the United States and Europe. Classified by Underwriters' Laboratories, Inc. Mail coupon for details.

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cess to the housekeeper at all times and that she welcomes suggestions to improve the service. Samples of new materials are frequently given out and a report on results is obtained. Serious consideration is given these findings when the next purchase is contemplated.

At this point it seems pertinent to add that one big factor in keeping the housekeeping personnel contented is adequate equipment with which to work. For example, the housekeepers and janitors are supplied with two of everything they require. In this way the mops, dry mops and the like, can be washed thoroughly in soapsuds, rinsed and hung out in the open air in good weather and in the boiler room in wet weather. We never have dingy, sour smelling equipment and the maintenance is actually less on account of the care given.

One piece of equipment has saved untold labor and has paid for itself over and over. This is the dusting mop used in the corridors. It is wide enough so that by going up the corri-

dor on one side and down on the other, the entire floor is covered. This mop is composed of 16 ply staple cotton yarn with 11 inch strands in 12 inch sections fitted into a divided block held together with screws. The mop is 48 inches long. The cost is \$5 each. The 12 inch sections can be purchased for 40 cents each. This dust mop is the only exception to the daily washing schedule. It is taken outside and thoroughly brushed with a whisk broom and is washed monthly. We have one of these mops for each janitor and they have been in use for four years and are just now in need of replacement.

The sanitarium is divided into five housekeeping departments. These are: (1) first floor, accommodating 11 patients, the library, the recreation room, the x-ray and clinical laboratory and the general supply rooms; (2) second floor, accommodating 24 patients, a small operating room, staff offices and business office; (3) third floor, accommodating 31 patients, in addition to the present nurses' quarters, housing seven nurses; (4) cot-

tages A and B, accommodating 26 patients; (5) the employees' quarters, in which live 3 nurses, 13 other women employees and 8 men. There will be a sixth department when our new residence to house nurses, one woman physician and all other women employees is ready for occupancy. At that time the employees' quarters will be remodeled to house a resident physician and men employees.

The kitchen, service kitchen and refrigerating rooms have not been included in the housekeeping departments, because the cooks and service kitchen girls take entire care of their departments except for the floors.

We have in each department, except the employees' quarters, a housekeeper who is responsible for all patients' rooms and wards, bath, utility and chart rooms and the final dusting of the floors. There is a housekeeper on each floor every morning from 7 to 11:30 o'clock, except one day each week, when the time is extended the full eight hours. On this day, other than routine work

Service Kitchen and Housekeepers

Services and Personnel*	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A—S.K.....	6-12:30 4-7	6-3	Day	6-12:30 4-7	6-2 5-6:30	6-12:30 4-7	6-12:30 4-7
B—S.K.....	6-2 5-6:30	6-12:30 4-7	6-12:30 4-7	6-2 5-6:30	6-12:30 4-7	1 hr. 6-2	Day
C—S.K.....	6-12:30 4-7	6-12:30 4-7	6-3	Day	6-12:30 4-7	6-2 5-6:30	6-2 5-6:30
D—S.K.....	6-3	Day	6-2 5-6:30	6-12:30 4-7	6-2 5-6:30	6-12:30 4-7	6-12:30 4-7
Third Floor Housekeeper.....	Floor-7-11:30 S.K.-12-2 S.K.-4:30-6:30	Floor-7-11:30 S.K.-12-2 Floor-2-3:30	Day	S.K.-6-7:30 Floor-7:30-11:30 S.K.-12-2 S.K.-5:30-6:30	Floor-7-3:30	Floor-7-2 S.K.-4:30-6:30	S.K.-6-7:30 Floor-7:30-11:30 S.K.-12-2 Floor-2-3
Second Floor Housekeeper.....	Floor-7-11:30 S.K.-12-2 Floor-3-4:30	Floor-7:00-11:30 D.K.-12-2 D.K.-4:30-6:30	Floor-7-11:30 S.K.-12-2 S.K.-4:30-6:30	Floor-7-11:30 S.K.-12-2 S.K.-4:30-6:30	Floor-7-3:30	Floor-7-11:30 S.K.-12-2 Floor-2-3:30	Day
Cottage Housekeeper.....	Cot.-7-2 S.K.-4:30-6:30	Cot.-7-11:30 S.K.-12-2 S.K.-4:30-6:30	Cot.-7-11:30 S.K.-12-2 S.K.-4-6	Cot.-7-11:30 S.K.-12-2 Cot.-2-3:30	Cot.-7-3:30	Day	Cot.-7-11:30 S.K.-12-2 S.K.-4:30-6:30
Relief Housekeeper	Day	S.K.-6-7:30 E.Q.-7:30-11:30 S.K.-12-2 S.K.-5:30-6:30	S.K.-6-7:30 Floor-7:30-11:30 S.K.-12-2 S.K.-5:30-6:30	E.Q.-7-3:30	N.Q.-7-11:30 E.Q.-12-3:30	Cot.-7-11:30 S.K.-12-2 S.K.-4:30-6:30	Floor-7-11:30 S.K.-12-2 S.K.-4:30-6:30
Asst. Kitchen and Service Kitchen..	12-2	Day	12-2	12-2	12-2	12-2	12-2
Extra Relief Housekeeper.....	0	0	0	E.Q.-7-3:30	N.Q.-7-11:30 S.K.-12-2 S.K.-4:30-6:30	0	0

S.K., Service Kitchen; N.Q., Nurses' Quarters; E.Q., Employees' Quarters; D.K., Diet Kitchen; Cot., Cottage.

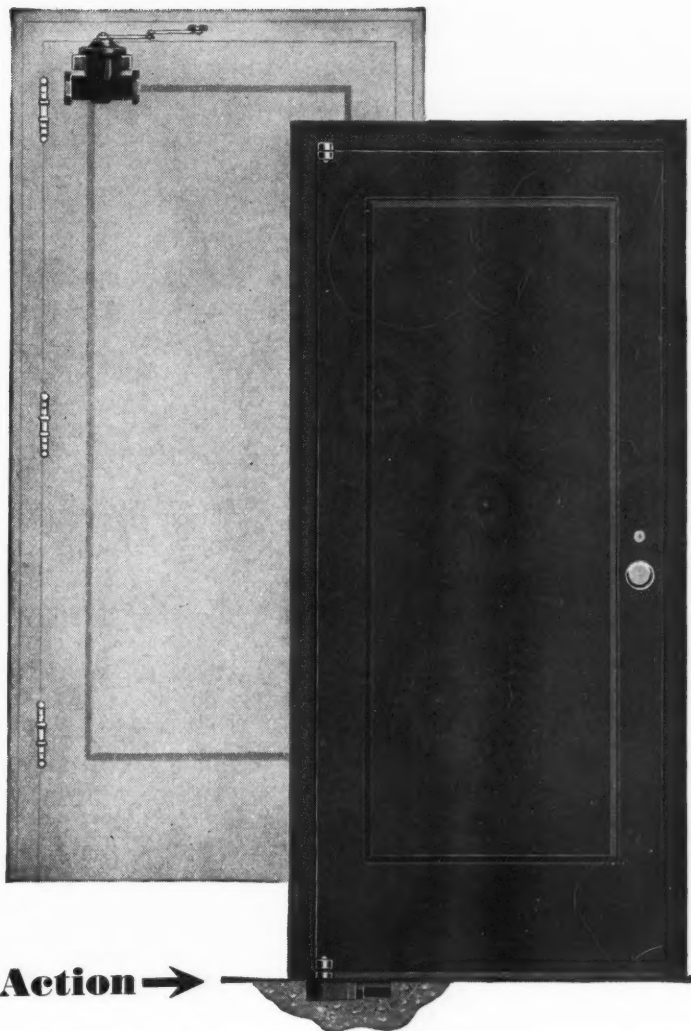
\*Half hour off for meals.

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a Beauty in Both Design and Action→



●At long last, awkward, unsightly overhead door checks need no longer be accepted as a necessary evil. They can be displaced by the specification of Rixson UNI-CHECK—at about the same cost level. UNI-CHECK is installed in the floor, practically out of sight. It enhances the appearance of a fine door with its small top and bottom pivots instead of bulky hinges.

UNI-CHECK requires only  $2\frac{5}{8}$  inches of floor depth: Can be readily installed in any type of floor with or without a threshold. It closes the door gently and positively. There are only six sturdy moving parts and no complicated adjustments to make.

## RIXSON UNI-CHECK

*For Single Acting Interior Doors*

UNI-CHECK is suitable for any single swing interior door, wood or metal, and no unsightly arms project whether the door is open or closed.

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London, Ontario, Canada





**Cooks and Service Kitchen**

<i>Personnel*</i>	<i>Monday</i>	<i>Tuesday</i>	<i>Wednes- day</i>	<i>Thurs- day</i>	<i>Friday</i>	<i>Satur- day</i>	<i>Sunday</i>
First Cook.....	5-2	9:30-6:30	5-2	Day	5-2	5-2	5-12 4-6:30
Second Cook.....	9:30-6:30	5-2	Day	5-12 4-6:30	9:30-6:30	9:30-6:30	9:30-6:30
Third Cook.....	9:30-6:30	5-12 4-6:30	9:30-6:30	9:30-6:30	5-12 4-6:30	5-2	Day
Fourth Cook.....	5-2	5-2	5-12 4-6:30	5-2	Day	9:30-6:30	5-2
Asst. Kitchen and Service Kitchen..	5-12	Day	5-9:30 2-4	5-9:30 2-4	5-9:30 2-4	5-9:30 2-4	5-9:30 2-4

\*Half hour off for meals.

is attended to: beds and transoms are washed and the many small things that cannot be cared for on the regular routine are done. We maintain an eight hour day, six day week schedule but the hours are divided except for the day mentioned previously.

On the 7 to 11:30 a.m. days, the women spend the rest of the eight hour day in the service kitchen, assisting the service girls from 12 to 2 p.m. and from 4 to 6:30 p.m. All dishes are washed, trays set up, salads and desserts apportioned in this kitchen. It is unfortunate that the housekeeping and food service must be more or less combined but, because ours is a small institution with limited means, it has been found neither practical nor economical to maintain sufficient personnel to keep these departments entirely separate.

In each of the foregoing departments, except the employees' quarters, we have a janitor. His duties are many and varied but, primarily, he is a department janitor whose duty it is to gather all waste and take it to the incinerator, brush all floors in the early morning, dust corridors and keep all floors scrubbed and waxed.

We mop our rooms with tepid water once a week and, when necessary, scrub and re wax monthly. Corridors are mopped daily with tepid water and all stairs, bath and utility rooms are scrubbed daily. From 1 to 3 p.m., which is the patients' rest period, there is little or no traffic; the corridors are mopped at this time and the utility room floors are thoroughly cleaned. The men's bathrooms, too, get a second thorough cleaning. It is a difficult task to keep men's bath-

rooms in order, regardless of the time spent on them.

The janitors, too, are of necessity brought into the food service department. They convey electrical food carts and the tray carts from the kitchen to the departments, each of which has its own food and tray cart. They maintain the floors in the dining room, service kitchen and kitchen. At tray time they step from the rôle of janitors, scrub their hands, cover their floor clothes with cotton denim coats and become bus boys,

helping the department nurses to serve the trays.

The employees' quarters are thoroughly cleaned every Thursday, when the bed linen is changed. The relief housekeeper, who relieves in each department on the regular housekeeper's day off, attends to the employees' quarters with the help of one extra woman, who is employed two days a week. Friday, the nurses' quarters are thoroughly cleaned and the beds changed by the same women. Except for this weekly service, all sanitarium employes make their own beds each day before coming on duty.

The nurses' rooms are dusted and the bathrooms cleaned daily by the third floor department housekeeper. The employees' quarters are dusted and the bathrooms cleaned three times a week, in addition to the thorough cleaning once a week.

For the yearly cleaning of walls and woodwork the sanitarium contracts with local professional decorators. We also contract for our window washing.

The cost of janitors' supplies for the year 1937 was \$219.12.

## What Makes a Good Housekeeper?

"COOPERATION and coordination are the primary essentials of a good housekeeper," said L. M. Arrowsmith, superintendent of St. John's Hospital, Brooklyn, N. Y., addressing the January meeting of the New York chapter, N.E.H.A.

"A certain patient seemed every day to find something the matter with the hospital," he went on. "One morning the report I found on my desk from her said that the 'food was cold.' I called the dietitian and she proved to me that the food couldn't have been cold. The next morning she complained that the room was too hot. But the building supervisor convinced me that it couldn't have been too hot. The following day the report said that our porters didn't know how to mop a floor.

"So I called the housekeeper. She thought a moment and then said, 'The tendency to complain goes

with the illness this woman is suffering. We'll just give the porter a lesson in mopping in her room so that she can see that her complaint is having attention.'

"The next morning the housekeeper did just that. There was never another complaint from this patient. That is what I mean by 'cooperation.'"

While accidents in hotels have decreased steadily in the last three years, in hospitals they have been on the increase. The Greater New York Hospital Association has formed a safety committee of which one subcommittee deals with the safety of walkway surfaces. W. P. Collins, assistant superintendent of Lenox Hill Hospital, New York, chairman of the subcommittee on floor safety, said that accident insurance rates can be cut down by actual thought as to what the floor is made of, and then by determining what product to use in making it nonslip.

## RECENT ADVANCES IN THE SCIENCE OF NUTRITION

### VI. The Chemical Identification of Thiamin or Vitamin B<sub>1</sub>

● An outstanding accomplishment of American Biochemical research has been the chemical identification—by degradation and by synthesis—of thiamin or pure vitamin B<sub>1</sub> (1). Thus, another dietary essential long known by its physiologic functions has been identified chemically, in this instance as a quaternary thiazole.

This discovery is of the most basic importance in the field of vitamin B<sub>1</sub> research. Determination of the chemical nature of this factor permits not only explanation of certain previously known facts concerning vitamin B<sub>1</sub>, but in addition, has opened new fields of research. One of these is already concerned with the development of a reliable chemical method for estimation of thiamin which will be generally applicable to foods.

At present, quantitative determination of vitamin B<sub>1</sub> necessarily requires the use of one of the several bioassay methods available for that purpose. None of these is entirely satisfactory (1, 2). Perfection of a chemical method for quantitative measurement of thiamin in foods would add greatly to our knowledge of its occurrence in nature,

as well as permit more comprehensive studies of factors which might influence the stability of vitamin B<sub>1</sub> in foods. We have a relative paucity of such data relating to vitamin B<sub>1</sub> when the available information on vitamin C is considered.

It should also be stated that the synthesis of thiamin—which is now produced on a commercial basis—has already provided the clinician with a most useful diagnostic tool. Administration of the pure vitamin in cases of suspected thiamin deficiency, with notation of the therapeutic response, constitutes the most trustworthy means of detecting avitaminosis B<sub>1</sub>. After the diagnosis has been confirmed and the immediate deficiency corrected by administration of thiamin, it is desirable that future adequate supply of vitamin B<sub>1</sub> be obtained through dietary readjustments (1).

In this connection, commercially canned foods deserve particular mention. Nutritional research (3, 4) on various members of this class of foods has demonstrated their potential value when included in a varied diet calculated to supply optimal amounts of vitamin B<sub>1</sub>.

## AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

- (1) 1938. J. Amer. Med. Assn. 110, 727.  
(2) 1938. Ibid. 111, 927.  
(3)a. 1936. J. Nutrition 11, 383.  
b. 1936. J. Amer. Diet. Assn. 12, 231.

- (4)a. 1932. J. Nutrition 5, 307.  
b. 1932. Ind. Eng. Chem. 24, 457.

*We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the forty-fifth in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.*



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.



## Reducing the "Waste Line"

THE present dietary department of Massachusetts General Hospital, Boston, inherited a well-established system of waste control, put into practice in 1909. The housekeeping department faithfully weighed and recorded the daily waste over a period of many years. The data were always available to those interested in the figures although this interest was likely to be spasmodic, perhaps because the responsibility for the waste was divided. However, the record did fill a definite need in the dietary department and was continued until 1931 when a new position, that of ward dietitian, was created.

With 17 wards to cover she could hardly assume much responsibility on any one ward but became "ambassador-at-large." The dietitian in charge of special diets had been the only one in touch with the wards before this time. Naturally, the new dietitian was confronted with so many problems she hardly knew where to begin, and, of course, she wished to be as helpful as possible to the doctors, nurses, administration and her own department. The "garbage book" served as an excellent record.

A healthy competition was developed among the nurses to cut their waste down by smaller servings and closer attention to the patients' likes and dislikes. The latter tendency brought about many changes in menu items. The total poundage of waste for that year and following years steadily decreased as a graph of the period shows, although there was a wide variation from time to time.

The following is taken from the annual report of the dietary department for the year 1936. "Study of food waste: to satisfy patients and personnel has always been the aim of this department. In 1931 we be-

Miss Floyd is the chief dietitian, Massachusetts General Hospital, Boston.

MARION D. FLOYD

gan to chart the amount of food waste from the wards in an attempt to reduce it materially." That our ambition has been realized is clearly shown in table 1.

Until 1934 the responsibility for the control of the food waste was divided; the dietary department made the menus and prepared the food, the housekeeping department distributed the food and collected the waste, the nursing department served the trays. Then the dietary department was given the full responsibility for the entire food service of the hospital. Our success was

Table 1—Amount of Food Waste in Wards per Person per Day, 1931-36

Year	Actual Waste <sup>1</sup> (Oz.)	Estimated Waste <sup>2</sup> (Oz.)
1931.....	25.7	9
1932.....	20	7
1933.....	16	5.6
1934.....	13.4	4.7
1935.....	12	4.2
1936.....	3.5	...

<sup>1</sup>Edible and inedible; <sup>2</sup>edible.

Table 2—Comparative Study of Food Ordered for Wards A and F for Two Twenty-Four Day Periods Before and After Dietary Department Supervision

Ward	Item	Before	After	Saving
F	Butter	1210 oz.	768 oz.	442 oz. (27 lbs.)
A	Butter	1319 oz.	930 oz.	389 oz. (24 lbs.)
F	Eggs	54 doz.	19 doz.	35 doz.
A	Eggs	28 doz.	14 doz.	14 doz.
F	Lemons	8 doz.	10 $\frac{1}{3}$ doz.	2 $\frac{1}{3}$ doz. extra
A	Lemons	15 doz.	12 doz.	3 doz.
F	Oranges	72 doz.	28 doz.	44 doz.
A	Oranges	40 doz.	22 $\frac{1}{2}$ doz.	27 $\frac{1}{2}$ doz.
F	Milk	705 qts.	561 qts.	144 qts.
A	Milk	566 qts.	523 qts.	43 qts.
F	Cream	96 qts.	—	25 pts. 40%
A	Cream	50 pts.	—	45 pts. 20%
F	Bread	164 loaves	141 loaves	23 loaves
A	Bread	292 loaves	143 loaves	149 loaves
F	Ice Cream	102 servings	29 servings	72 servings (9 qts.)
A	Ice Cream	98 servings	30 servings	68 servings (8 $\frac{1}{2}$ qts.)

to be measured by the satisfaction of the food to the patients and personnel and the economy with which we could carry out our task.

With such a challenge no problem seemed too difficult to tackle. To be able to take over the ward service, the floor service at Baker Memorial, the food store and the distribution of food from the store and kitchens was too good to be true. The responsibility for the food store meant a check on the waste there, better correlation of ordering from the different units of the department and closer cooperation in planning menus. The distribution of supplies from the store was more flexible to our needs. For example, the ward supplies, previously ordered two and three meals before they were delivered, could be ordered after dinner and delivered within an hour, while the maids were still in the kitchens to put them away in locked iceboxes.

Then the fact that the dietitians were responsible for the food ordered for the wards decreased the waste. A comparison of two twenty-four day periods before and after taking



## *Chef Harrison found the foods he was looking for...after a 10-year search!*

**H**AVE you ever wondered why all your care in preparation couldn't make most market-fresh vegetables taste better?

Well, Lloyd Harrison, head chef of the famous Milam Cafeteria in San Antonio, wondered about that, too. Tried to figure out why a way couldn't be found to serve a *variety* of vegetables that *uniformly* had that fresh-from-your-own-garden flavor.

Quite a question when you have to answer it and maintain a consistent *profit!* And it took 10 years of testing before Mr. Harrison found the answer—BIRDS EYE FROSTED FOODS! But here are his own words:

*"We are now serving your Birds Eye Fruits and Vegetables in large quantities. The public is well pleased with these products because of their superior garden freshness. And I have never used any products that save on waste, time and cost as do Birds Eye Frosted Foods. I put them on my menu as often as possible."*

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over two wards serving about 60 patients is shown in table 2. The total value of the savings effected in these two wards was \$60.32. That did not mean that the dietitians cut down on all supplies, for the total amount of milk ordered was increased. We discontinued the preparation of between meal nourishments on the wards and sent them from the diet kitchen so that an actual saving on those supplies was difficult to determine. Later we brought about a further saving, with the approval of the doctors, by serving such nourishments only to patients on diets actually needing them, such as persons suffering from gastric disorders and those on a high caloric diet.

In our enthusiasm we undertook so much in 1934 that we were some time catching up with ourselves. However, by the fall of 1935 we were anxious to undertake the separation of the edible from the inedible food waste. We had taken over the collection and weighing of garbage from the housekeeping department the previous year and had reduced the amount considerably by reason of our responsibility for it and, therefore, our deepened interest in it. We knew, however, that until the inedible waste (potato skins, bones, grapefruit rind and the like) was separated we would not know the amount of actual waste. So, with Doctor Faxon's encouragement, we proceeded.

Setting up the mechanics of the new system was a problem but a routine was soon developed. We bought a set of smaller pails for the inedible waste but soon had to use them for the edible waste when that became so much smaller in amount. The housekeeping department had collected the waste three times a day, but the schedules of our employees did not allow for a collection more than once a day. This we have always made in the early afternoon, collecting, weighing, washing and returning the pails within a short time.

Space in the garbage room does not permit extra sets although some extra pails are kept on hand. Being firm believers in the definite placing of responsibility for all tasks, we have trained one man (and his relief) to handle all food waste. He weighs the pails, notes the contents

and reports mistakes in the separation of the waste.

The problem of educating the nurses and maids in the proper division of edible and inedible waste was the most difficult part of our new program. Thorough instruction was given at group meetings and written notices were posted. Daily reports and weekly averages were posted and discussed at the regular meetings of the nurses, dietitians and maids.

For the first time we really knew the edible waste per person on each ward each day. Why was the waste high on every ward Wednesday night? A certain menu item was noted consistently. The order went out either to rule it out or to improve the recipe. Why did ward X run high for several days? A new maid needed to be better trained. Was the food hot, were the dishes hot, were the servings too large? Perhaps a new nurse or student dietitian did not know her patients well enough. What to do about the continued appearance of bread in the waste? The answer was, put less on the trays and pass more during

the meal. One-half square of butter, we found, would do many times and would save another one-half square. And so it went.

What actually happened? Food that might have been eaten and was not averaged 8.6 ounces per patient per day when we started. In six months we had cut the figure down to 2.5 ounces per patient per day. Has the interest lasted? Are we able to maintain a low figure?

In 1936 we forced the edible waste per patient per day in Baker Memorial Hospital to 3.5 ounces. In 1937 it came down to 1.7 ounces. In General Hospital in 1936 our records showed a waste of 2.8 ounces. In 1937 this figure was 1.9 ounces.

Whether we can ever lower those figures I do not know, for they are less than 1 ounce per meal and seem to stay about the same. The minute anyone is careless with menu planning, preparation, service or watching likes and dislikes our barometer records it and the data indicate the place and the reason. Do you wonder I say we have a real motivating interest for the control of our food waste? I recommend the system.

## St. Valentine's Day Tray



Cream of celery soup, roast beef, baked potatoes, cauliflower and shoestring potatoes, tomato and cottage cheese sandwich salad, grapefruit and strawberry cup, coffee.—Prepared by Mary Edna Golder, chief dietitian, St. Anne's Hospital, Chicago.



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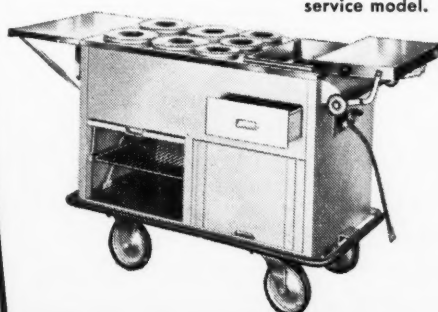
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# Employees' Health Service

LOUISE WILKONSON

THE organized health service for employes at Barnes Hospital had a beginning as almost everything else does: something happened to show us the need for it. In fact, several things happened to prompt the administration to ask the medical service to designate one of the assistant resident physicians to examine the employes and to serve as their physician, should they become ill.

Shortly after the Missouri Workman's Compensation Act was introduced, we had two outstanding incidents that showed the advisability of examining employes before they were placed permanently on the pay roll.

One day after lifting a can of milk, a man who had suffered from a hernia for twenty-three years complained of some slight pain and was examined by the resident physician. He found no change in the employee's condition but, for the man's own benefit, recommended a repair of the hernia. This was done at the expense of the hospital. Immediately upon being discharged from the hospital, the man obtained a lawyer and brought suit against us.

The second incident concerned an employee who had a brain tumor and who died during the operation that was deemed necessary. His widow claimed that a slight cut on the head received while on duty, but one that did not injure the skull in any way, was the cause of the brain tumor and brought suit before the Workman's Compensation Commission. Investigation revealed that this man had been treated in the clinic and that the diagnosis of brain tumor had been made before he was employed by the hospital.

The failure of the hospital to examine these two employes before placing them on the pay roll proved to be exceedingly embarrassing. The unfairness of the man with the hernia has been demonstrated repeatedly in St. Louis, until now the employers and the Workman's Compensation

The author is chief dietitian, Barnes Hospital, St. Louis.

Commission have made it practically impossible for a man with a hernia to bring suit.

The dietary department was particularly anxious to cooperate in developing this service for the employes because of the danger of transmission of disease and food poisoning by food handlers. Besides the assistant resident physician to treat them on the medical service, an intern on emergencies from the surgical service was designated to treat them in case of accidents. Hospitalization was given an employee whenever necessary. The beneficial effect both for employes and the hospital was immediately observed. Those unsuited

for duty either were not hired or they were put in certain positions where they could work efficiently. The satisfaction of a complete physical examination that found him in good health or brought to his notice an illness that needed attention was a direct benefit to the employee. A simple record system using a card was adopted at first, but continuous development has taken place and the first simple card was soon changed to the standard card illustrated here-with.

The service has made some devel-

opment each year, the amount depending upon the assistant resident physician. Some of the doctors have availed themselves of the opportunity to use the service for research. For example, one resident physician on this service did research on syphilis. It is not the custom at our hospital to discharge employes with a positive Wassermann. If an employee is in the infectious stage, he is required to remain off duty until the doctor is satisfied that he has had adequate treatment and is no longer infectious. Although this treatment is a great expense to the hospital in furnishing antisyphilitic medication,

BARNES HOSPITAL-MEDICAL EXAMINATION

Name	BARNES HOSPITAL-MEDICAL EXAMINATION										No.
Address	S.	M.	W.	Dept.	Date						
Age	Height ft.	in	Weight	lbs.	Temp.	Pulse	Resp.	B. P.	S.	D.	
1. Nutrition	24 VISION				25. HEARING						
2. Musculature	Distant, OD				OS	Watch, Right		ft.			
3. Cleanliness	Reading, OD				OS	" Left		ft.			
4. Ears	Astigmatism										
5. Eyes	Corrected										
6. Tonsils											
7. Teeth											
8. Nose											
9. Glands											
10. Goitre											
11. LUNGS											
12. HEART											
13. Abdomen											
14. Herniae											
15. Hemorrhoids											
16. Pelvis											
17. Feet											
18. Varicosities											
19. Deformities											
20. Hands											
URINE											
21. Albumin						Blood Kahn					
22. Sugar						Blood Widal					
23. Casts, etc.						Stool Culture					
FOLLOW UP:											

1-38 500 Form 127

for duty either were not hired or they were put in certain positions where they could work efficiently. The satisfaction of a complete physical examination that found him in good health or brought to his notice an illness that needed attention was a direct benefit to the employee. A simple record system using a card was adopted at first, but continuous development has taken place and the first simple card was soon changed to the standard card illustrated here-with.

employees are treated at the hospital rather than at the clinic.

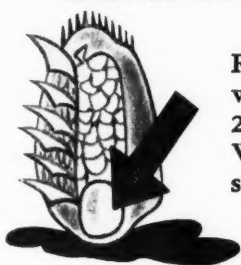
At the present time the procedure employed for running this service is definitely outlined. The assistant resident physician has regular office hours, 8:30 a.m. and 4:15 p.m. each week day and 9:00 a.m. on Sundays and holidays. Any employee who is ill reports to the head of his department, who sends him to the doctor at the appointed hour. (An emergency illness is taken care of as necessary.)

In the case of a new employee,

*"It has been estimated by Tisdall that more than half the foods in the ordinary American diet have no appreciable content of vitamin B<sub>1</sub>."*  
*\*Story of Vitamin B<sub>1</sub>, Tisdall, JAMA (1935) 105-1583*

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appointments are made ahead for the physical examination. This physical examination and smallpox vaccination are compulsory. Typhoid fever shots are optional. In addition to the points usually considered in a physical examination, special attention is given to the following: eyes, heart, presence of hernia, Wassermann or Kahn reactions. In all food handlers a stool culture for typhoid, amebic dysentery and the other dysentery bacilli and a Widal test are made.

After the assistant resident doctor has made his examination, he places the cards of new employes on the desk of the assistant superintendent, who then makes a notation of the approval or disapproval of the employe's physical condition on his application blank.

It is the usual custom for the doctor to notify heads of departments of any contemplated hospitalization or other matter of importance concerning an employe so that proper arrangements may be made for his time off duty, treatments or whatever it may be. This arrangement of getting first-hand information concerning the employe's illness is of great assistance to the department head in making work plans. Often the doctor is able to give notice ahead that an individual may have to be taken off duty or may be able to state when he can be expected back on duty, which helps to keep the business of the department running more smoothly.

The health of the employe is of particular importance to the dietary department since the knowledge that the food handlers have had recent negative stool culture for typhoid, amebic dysentery, paratyphoid and the other dysentery bacilli contributes greatly to the peace of mind of the administration and the dietitian when an outbreak of gastric upsets occurs among the personnel.

Without the security of the knowledge that the employes in the dietary department are in good health and have no transmissible disease, the slightest occurrence of diarrhea among the intern staff which is universally and notoriously critical of hospital food can cause endless worry. Almost invariably an intern will give amebic dysentery as the cause of illness and it is necessary to hospitalize

him until his stool cultures are shown to be negative.

It is our custom in the dietary department to keep a close check on the health of employes. They are sent to the doctor for minor ailments that perhaps would be ignored elsewhere. We have found that it is an extra safeguard to take an individual with a cold off duty and send him to bed whenever possible to prevent transmitting the cold to the other personnel. In the same manner, any other infection is removed from the sphere of work by isolation. A supply of soap and paper towels are kept in all washrooms and kitchens and the

employes are encouraged to wash their hands before and frequently during work as a safeguard.

The latest development in the health service has been the recent addition of the minimum amount of psychiatric study which will enable us to obtain some idea of the employe's personality. Is he a stable individual who may be depended upon? Is he adjusted to his position in life and is he comparatively happy in his job? If we knew even these few things about each individual in the department, it would help considerably in choosing the right person for the right job.

## RECIPES BY REQUEST

### Baked Spinach (Thirty Servings)

- 1 gallon cooked spinach
- 16 eggs, well beaten
- 1 cup butter
- 1 pint milk
- ½ cup flour

To chopped spinach add eggs and white sauce. Place in individual casseroles or one large baking pan. Place utensils in hot water and bake twenty minutes in a moderate oven.

### Shrimp Salad (Twenty Servings)

- 10 No. 1 cans shrimp
- 1 quart shredded cabbage
- 1 quart chopped celery
- 1 teaspoon salt
- 7 medium tomatoes
- 3 cups mayonnaise
- Watercress
- Lettuce

Clean and cut shrimp; mix with cabbage, celery, mayonnaise and salt; place on crisp lettuce; garnish with watercress and sections of tomato.

### Salmon Creole (Fifty Servings)

- 8 1 pound cans salmon
- 1 cup butter
- 1 cup chopped onion
- 5 cups buttered bread crumbs
- 1 No. 10 can tomatoes
- ¾ cup chopped green pepper
- Few grains cayenne pepper
- ½ teaspoon salt

Brown onion in melted butter; add tomatoes, peppers and seasoning. Put flaked salmon in baking

dish; cover with sauce; sprinkle with bread crumbs; bake in moderate oven (375° F.) for twenty minutes.

### Porky Pie (Fifty Servings)

- 12 pounds pork shoulder
- 3 pounds onions
- 2 cups fat
- 3 quarts hot water
- 1½ cups flour
- 3 tablespoons salt
- ½ cup sugar
- ½ teaspoon pepper
- 3 tablespoons paprika
- 2 dozen tart apples

Put pork and onions through grinder. Fry five minutes in fat, add water, simmer ten minutes and stir in flour mixed to a paste with a little cold water. Add seasonings. Cook three minutes longer. Peel apples and cut into thin slices. Sprinkle with sugar. Fill baking dish with alternate layers of apples and meat. Cover with sweet potato biscuits, which are made as follows:

- 2 quarts flour
- 5 tablespoons baking powder
- 2 quarts mashed sweet potatoes
- 4 teaspoons salt
- 1½ cups shortening
- 1 quart milk or water

Sift flour, baking powder and salt and cut in shortening. Lightly fold in sweet potatoes, add milk or water. Roll out to one-half inch in thickness on a floured board. Cut with a biscuit cutter and place close together on top of meat mixture. Bake in a hot oven forty minutes.

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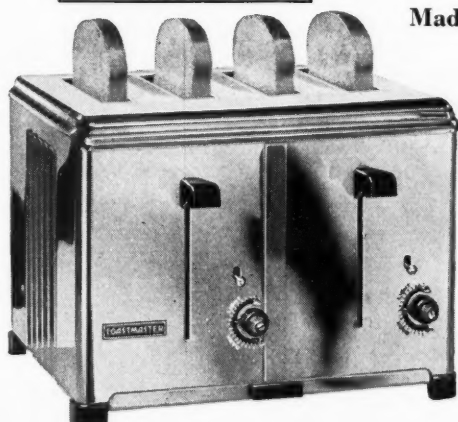
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# March Menus for the Small Hospital

Helen G. Roll

Dietitian, Johnston-Willis Hospital, Richmond, Va.

## BREAKFAST

## SUPPER

Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Applesauce	Toast, Fish Roe and Eggs	Broiled Sweetbreads	Spanish Rice	Celery, Lettuce, Dressing	Baked Apple, Cream
2.	Grapefruit	Poached Eggs, Spoonbread	Creamed Eggs	Potatoes on Half Shell	Tomato Salad	Sliced Peaches, Cookies
3.	Stewed Prunes	Fluffy Omelet, Muffins	Escalloped Oysters	Potato Salad	Buttered Green Peas	Fruit Cup
4.	Orange Juice	Bacon, Scrambled Eggs, Hot Rolls	Veal Liver and Bacon	Buttered Potatoes	Perfection Salad	Applesauce
5.	Honeydew Melon	Shirred Eggs, Biscuit	Baked Virginia Ham	Baked Potatoes	Creamed Asparagus	Fresh Strawberries and Cream
6.	Tangerines	Broiled Salt Mackerel, Butter Sauce, Corn Muffins	Meat Patties, Mushroom Sauce	Lima Beans	Fruit Salad	Spice Cakes
7.	Grapefruit Juice	Canadian Bacon, Apple Rings, Bran Muffins	Roast Beef and Relish	Corn Pudding	Buttered Beets	Pineapple Bavarian Cream
8.	Prunes and Orange	Creamed Chipped Beef, Batterbread	Cheese Omelet	Creamed Diced Potatoes	Stuffed Tomato Salad	Canned Apricots, Date Bars
9.	Baked Apples	Coddled Eggs, Biscuit	Broiled Chicken Livers on Toast	Creamed Potatoes	Grapefruit Salad	Gingerbread and Whipped Cream
10.	Grapefruit Sections	Poached Eggs, Toast, Jelly	Chicken Hash or Escalloped Salmon	Grits	Cranberry Jelly, Salad	Sally Lunn, Raspberry Preserves
11.	Honeydew Balls	Bacon Curls, Orange Marmalade, Hot Rolls	Creamed Sweetbreads	Au Gratin Potatoes	Buttered Brussels Sprouts	Poached Peaches
12.	Grapes	Scrambled Eggs, Bacon, Muffins	Oyster Stew	Potatoes on Half Shell	Asparagus, Cheese Sauce	Apple-Raisin Salad
13.	Sliced Bananas	Brains and Eggs, Biscuits	Chicken Liver Omelet	Carrots and Peas	Avocado Salad	Baked Apples
14.	Orange Slices	Giblet Hash, Spoonbread	Creamed Shrimp	Buttered Potatoes	Brussels Sprouts	Grapefruit-Orange Salad
15.	Honeydew With Lemon	Canadian Bacon, Muffins	Broiled Lamb Chops	Browned Sweet Potatoes	Asparagus Salad	Pears Romanoff
16.	Frosted Raspberries	Creamed Eggs on Toast	Salmon Loaf	Creamed Green Peas	Carrot Salad	Pineapple Upside-Down Cake
17.	Figs	Bacon or Scrambled Eggs, Biscuit	Baked Rockfish	Parsley Potatoes	Broccoli, Lemon Butter	Wine Jelly, Custard
18.	Grapefruit Juice	Poached Eggs, Corn Muffins	Tomato Stuffed With Chicken Salad	Baked Potatoes	Spinach	Gingerbread With Custard
19.	Grapes	Bacon, Scrambled Eggs, Hot Rolls	Panned Oysters	Au Gratin Potatoes	Buttered Asparagus	Peach Basket Salad
20.	Fruit Compote	French Omelet, Biscuit	Cold Sliced Virginia Ham	Baked Sweet Potatoes	Lettuce, Russian Dressing	Fruit Cup
21.	Grapefruit	Coddled Eggs, Muffins	Broiled Squab	Escalloped Corn	Macedoine Salad	Pineapple Ice Box Pudding
22.	Figs	Toast, Shirred Eggs	Shad Roe, Bacon	Creamed Potatoes	Tomato Salad	Royal Anne Cherries
23.	Grapes	Bacon, Scrambled Eggs, Biscuit	Chicken à la King	Grits	Carrot Straws	Ambrosia
24.	Honeydew Balls	Jelly Omelet, Corn Muffins	Cheese Soufflé	Baked Potatoes	Perfection Salad	Apple Whip, Custard
25.	Stewed Prunes	Corned Beef Hash, Poached Eggs, Toast	Escalloped Oysters	Creamed Diced Potatoes	Brussels Sprouts, Lemon Butter	Lime Gelatin and Pears, Whipped Cream
26.	Applesauce	Coddled Eggs, Biscuit	Individual Meat Pie With Vegetables	Creamed Potatoes	Green Bean and Pimiento Salad	Strawberries and Cream, Oatmeal Cookies
27.	Sliced Bananas	Shirred Eggs, Muffins	Meat Balls	Spaghetti, Tomato Sauce	Pecan and Royal Anne Cherry Salad	Chocolate Ice Box Pudding
28.	Tomato Juice	Fish Roe, Eggs, Corn Squares	Broiled Sweetbreads and Mushrooms	Au Gratin Potatoes	Orange, Grapefruit and Avocado Salad	Wine Jelly, Whipped Cream
29.	Grapefruit	Bacon Curls, Apple Rings, Biscuit	Broiled Chicken Livers on Toast	Potatoes on the Half Shell	Asparagus Salad, Russian Dressing	Fresh Fruit Cup
30.	Frosted Raspberries	Omelet, Toast	Roast Beef, Brown Gravy	Creamed Diced Turnips	Stuffed Prune Salad on Pineapple	Angel Cake, Chocolate Sauce
31.	Baked Apples	Bacon or Scrambled Eggs, Corn Muffins	Chicken Hash or Creamed Shrimp	Steamed Rice	Tomato Aspic	Caramel-Pecan Whip

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

# PEPTIC ULCER PAIN RELIEF FROM U.S.P. GELATINE (KNOX)

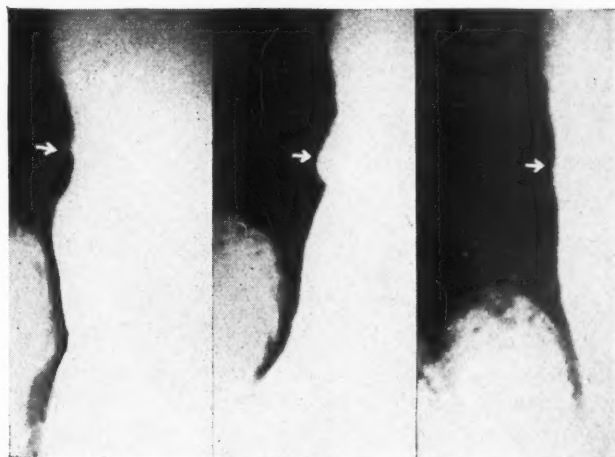
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A simple formula for the preparation of concentrated Knox Gelatine feedings, useful



CASE I — FEMALE, 74

Uncomplicated gastric ulcer first demonstrated by Roentgen rays in 1934. Diet and alkalies afforded little relief. Accompanied by loss of weight. Repeated X-ray studies in 1936 and 1937 showed no improvement. She was placed on a diet-gelatin regime in November, 1937. Relief immediate. Gained weight. Roentgen studies in April, 1938, showed no demonstrable ulcer.

in peptic ulcer is, stir quickly one envelope (approximately 8 grams) of Knox Gelatine in  $\frac{3}{4}$  of a glassful of drinking water and have patient drink quickly before it "sets" or gets lumpy.

\*Windwer and Matzner, *Am. Jl. Dig. Dis.*

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# Hospital Pharmacy

## The Forgotten Department

MALCOLM T. MacEACHERN, M.D.

**D**RUG THERAPY still maintains an important place in the practice of medicine despite the rapid advances of surgery, physical therapy and other means of treating the sick. The modern hospital must be prepared to provide this service for the physician if it is to fulfill its obligation for complete and efficient service to the patient. The medical staff and the management of the hospital must realize fully the importance of the efficient pharmacy from the standpoint of the scientific practice of medicine, the education of interns, nurses and doctors and the economic administration of drug therapy.

The beginning of a new section in *The MODERN HOSPITAL* devoted to the hospital pharmacy is another step in the widespread movement to elevate the pharmacy from its place as the forgotten department of the hospital. It is almost too much to expect that all of the many departments of the hospital will advance, both professionally and administratively, at a uniform pace. But when any part of the hospital organization drops appreciably behind the others, it becomes, or should become, the object of concentrated interest and efforts directed toward advancing it to a position equal to that of the other departments in the quality of the service it renders.

We are forced to recognize that in many hospitals it is the pharmacy department which has lagged behind and been forgotten, or has been forgotten and therefore lagged behind. We have the word of the committee on pharmacy of the American Hospital Association that "few departments in hospital performance have been given less attention, by and large, than the hospital pharmacy. The present practice of

drug therapy in hospitals is chaotic and requires revision. There is great economic loss in the operation of the average hospital pharmacy as it is today administered."

Good hospital service presupposes good pharmaceutical service. No hospital seeking to maintain high quality in the care that ultimately reaches the patient can be delinquent in respect to the professional and ethical standards of the pharmacy, a fundamental in patient care.

Thus there has come about a new concentration of attention upon this department. The pharmacy service is of intimate concern to many of the personnel of the hospital: physicians, nurses, pharmacists and administrators. It is no longer considered the exclusive concern of the technical expert. Improvement in the pharmacy service depends not upon the pharmacist alone but upon all these persons.

Hospital administrators should study carefully and comply as closely as possible with the essentials for

### Minimum Standard for Pharmacies in Hospitals

**1. Organization.** The hospital shall have pharmaceutical service: (a) the full time of a graduate registered pharmacist, or (b) pharmaceutical service from an approved near-by pharmacy.

**2. Committee.** The hospital shall appoint a pharmacy committee, which shall meet at regular intervals. The members of the committee shall be chosen from the several divisions of the medical staff. The pharmacist shall be a member of the committee and shall serve as its secretary. He shall keep a transcript of proceedings and forward a copy to the proper governing board of the hospital.

The purposes of the pharmacy committee shall be: (a) to determine the policy of operation of the pharmacy and to deal with such other matters of a pharmaceutical nature as may from time to time arise; (b) to add to and delete from the drugs used; (c) to supervise the purchase and issuance of drugs, chemicals, pharmaceutical preparations, biologicals and supplies within the hospital.

**3. Library.** The hospital shall maintain an adequate pharmaceutical reference library: (a) *United States Pharmacopeia*, *National Formulary*, *New and Nonofficial Remedies*, *United States Dispensatory*, reference works on inorganic, organic and quantitative chemistry, pharmacology and toxicology, bacteriology, and a medical dictionary; (b) the *Journal of the American Medical Association*, the *Journal of the American Pharmaceutical Association*, the *Year Book of the American Pharmaceutical Association*, the federal regulations relative to the dispensing of alcohol and narcotics and a copy of the state and municipal pharmacy laws and sanitary code.

**4. Standards.** The hospital shall use drugs, chemicals, and pharmaceutical preparations of at least *United States Pharmacopeia*, *National Formulary* and *New and Nonofficial Remedies* quality in the treatment of patients.

**5. Supervision.** The pharmacist shall have immediate supervision over: (a) the routine preparation of injectible medication and sterilization of all preparations he himself prepares; (b) the routine manufacture of pharmaceuticals; (c) the dispensing of drugs, chemicals and pharmaceutical preparations; (d) the filling and labeling of all drug containers issued to nursing units from which medication is to be administered; (e) a semimonthly inspection of all pharmaceutical supplies on nursing units; (f) the maintenance of an approved stock of antidotes in the emergency suite; (g) the dispensing of all narcotic drugs and a perpetual inventory of them; (h) specifications for purchase of all drugs, chemicals and pharmaceutical preparations used in the treatment of patients; (i) specifications for purchase and storage of biologicals and all operations wherein a special knowledge of pharmacy, including a ready knowledge of weights and measures in all systems, is necessary.

Doctor MacEachern is associate director of the American College of Surgeons.



## Petrolagar Plain

### AN ADJUNCT TO THE RESTRICTED DIET

During a period of restricted diet, bowel regularity may be maintained with the aid of Petrolagar Plain. As an adjunct to the diet, Petrolagar induces a soft, well-formed stool and encourages a regular habit time for bowel movement.

If the case is severe, Petrolagar

Plain may be given in alternate doses with Petrolagar with Cascara until proper elimination is established. Then Petrolagar Plain alone will assist in maintaining a regular, comfortable movement.

There are five types of Petrolagar to suit the individual case.

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an ethical and efficient department that have been formulated by the American College of Surgeons in cooperation with a committee of the American Pharmaceutical Association.

The American College of Surgeons expects approved hospitals to comply with the requirements of the accompanying minimum standard which it has promulgated.

before a prescription is filled to be sure that they are within safe limits, for it is a simple matter to misplace a decimal point in writing a prescription, a mistake that might result in a lethal dose.

These responsibilities together with other controls in medications, should be placed in the hands of a competent pharmacist. He should be a person especially trained to watch out for just such mistakes. A trained pharmacist, in the event he questions the size of a dose, can simply call the prescribing physician and inform him diplomatically that the dose appears to be excessive and can ascertain whether or not such a large dose was intended. In the event the physician specifically intended an unusually large dose, this information should be clearly shown on the container label.

All medications for external use or preparations of a poisonous nature should be properly labeled in red. This, together with a clear statement that the medication is dangerous and should be used with caution, is of the utmost importance both to the patient and to the hospital. This information is vital to the patient for its own obvious value and probably is even more vital to the hospital. In the event

## Preventing Mistakes

B. T. HOWILER

THE pharmacist in his rôle as compounder of the physician's orders must exercise extreme care and skill to obtain the accuracy necessary in medications dispensed to the sick. He is constantly handling extremely potent and poisonous drugs and chemicals and handling them in doses that require knowledge and clear thinking.

If the pharmacist is in a hospital that maintains both in-patient and out-patient service, he is confronted with the problem of dispensing medications under totally different circumstances. It has been my experience that even though both types of patients require comparable therapy in many respects, there is a definite separation in the types of materials used and in the methods of administration for bed patients in the hospital and for ambulatory or out-patients.

Medication for ambulatory patients is usually prescribed in quantities sufficient for from ten days to two weeks' treatment, whereas for bed or hospital patients orders may be changed daily, so that medication is not ordered in any quantity. Clear, concise typed instructions or directions should be placed on all drugs given to a patient for self-medication. This fact should be borne in mind particularly for patients of foreign extraction, who often are unable to read profuse directions or who are unable to understand the prescribing physician's verbal directions. For this reason, it seems a good policy to ascertain whether or not the individual receiving the medicine clearly understands the instructions for its use.

In handling medications for bed patients, it is our policy in the University of California Hospital, San Francisco, to label the contents of

the container in terms of so many grams to the cubic centimeter or so many grams to the tablet or powder. If the medication is a mixture, we label the container so as to show the amount of each constituent each single dose contains.

An exception is made to this rule in the case of "going home medications" for which we follow the same procedure as outlined for out-patient prescriptions. We have an iron-clad rule that under no circumstances may a nurse ever put a label on a container. To prevent this occurrence, we carefully watch to see that labels are never given out at the pharmacy.

Constant vigil must be kept to see that an improperly labeled or an unlabeled container never leaves the pharmacy. Dosages must be checked

### RECEIPT OF DELIVERY

Nº 101

Date Issued.....  
Received of the Pharmacy.....Tablets of.....  
for.....  
Signed.....  
Ret'd Unused.....  
Date Sheet Ret'd.....

Date Sheet Ret'd

### UNIVERSITY OF CALIFORNIA HOSPITAL NARCOTIC RECORD

Nº 101

To the Pharmacy:  
The following is an accurate record of.....Tablets of.....  
as used on.....  
Signed.....  
Head Nurse

Record losses in detail, including individual responsible.

Date	No.	Patient	Location	Physician	Reg. No.	Drug and Amount	Issued to	Remarks
	1							
	2							
	3							
	4							
	5							

A numbered narcotic record sheet is used at this university hospital.

The author is chief pharmacist, University of California Hospital, San Francisco.

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Cleanliness . . . . .  
Security and Safety .  
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Available in larger sizes for larger consumers offering greatest economy consistent with adequate protection.

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of a damage suit, for example, a poison in a container not so marked could become damaging evidence.

It might be well to emphasize here that under no conditions should an unlabeled, an illegibly labeled or an improperly labeled medication ever be used. Better throw it away and order a replacement than to take a chance on the possible consequences.

Ward medications are those medications that are stocked in each ward or unit and are used for all patients requiring them as compared to those medicines ordered for individual patients. In this group of ward medications we commonly find such solutions as tape remover, bichloride of mercury, boric acid, mercury oxycyanide, normal saline, alcohol and a host of other solutions that are all clear water-white in color.

To minimize the possibility of error in the use of such solutions, we have adopted a set of color standards for all colorless solutions. For example, a characteristic green color has been adopted for mercury oxycyanide solution in 1 to 1000 concentration; all tape remover is colored a distinct orange; all sterile boric acid for irrigating purposes is made available in a light purple solution. In all cases we have kept the concentration of color below that which would stain linens.

Through this use of distinctly colored solutions, if a nurse in picking up a green solution did not stop to read the label, which we hope they all do, she would know by color association with a set of standards placed in each ward that the solution was mercury oxycyanide in a 1 to 1000 concentration.

I do not believe that the use of colored solutions tends to make individuals using them less observant of labels, but it does lead to the observation of a second precaution: in addition to noticing the label, the person using the solution automatically is on the lookout for a color identified with his mental picture of the solution.

Narcotics and hypnotics may be classed as separate entities because, in California and in several other states, the so-called "veronal laws" prohibit the sale of any barbiturates or barbituric acid derivatives without a doctor's prescription. These laws make the handling of barbiturates nearly comparable to the handling of nar-

## Growth of Hospital Pharmacy

LAST year the registered hospitals of the United States admitted more than 9,200,000 bed patients and approximately ten million out-patients. The former stayed a total of 344,700,000 days while more than 25,000,000 visits to out-patient departments were made by the latter.

So significant has been hospital growth that the *Journal of the American Medical Association* recently stated editorially that "hospitals are beginning to assume a dominant place in the practice of medicine and in the delivery of medical care to the American people." This growth is due to current economic developments and to increasing special equipment and services of hospitals.

One of the most important hospital services is that rendered by the pharmacy. When well run, this department has all the advantages of an ethical prescription pharmacy and it participates in the growing public favor and professional confidence reposed in such pharmacies.

Not only does the hospital pharmacist have a large number of in-patients and out-patients to serve each year but his duties are broadening in other directions. Today pharmacy schools are turning out well-educated graduates who are thoroughly professional in character and attitude. Such pharmacists can do more than merely fill prescriptions. They can assist in the education of interns, residents and nurses. They can advise helpfully with the medical staff on the selection of prescriptions and can act as a source of information and reference on new drugs. They can act as secretaries to the therapeutics committees of medical staffs. They can assist the administration through careful and intelligent buying through careful control of inventories and even through the manufacture of certain types of products.

So important has the hospital pharmacy become that many leading pharmacy educators are advocating a hospital internship for some of their graduates.

The new department on hospital pharmacy started in this issue is, therefore, a timely addition to The MODERN HOSPITAL service. Institutional pharmacy is growing up. It needs a suitable mouthpiece. This department will, we believe, fill a real need in that direction. Although devoted primarily to hospital pharmacy it will doubtless be of interest also to administrators, both medical and lay, and to members of the resident and visiting medical staffs.

cotics with the exception that in the case of hypnotics we are responsible only to the state, while in the case of narcotics we are responsible both to the federal and to the state governments.

In handling narcotics, it is not only a case of being strict in law but also a case of being exacting in practice. In the University of California Hospital we consider a chart order for narcotics as sufficient for only one dose at a time for a period not to exceed twenty-four hours. Thus, if a chart order for a 4 ounce cough medication containing a narcotic is received, even though that order has been written by the attending physi-

cian, we require a written signed prescription before the medication will be filled. In a like manner we require a prescription for all medications containing a narcotic in amounts larger than one dose for special patients.

So-called ward narcotic medication is handled in a somewhat different manner. We have provided numbered narcotic record sheets, herewith illustrated, upon which there are 25 numbered lines together with space to provide such information as patient, doctor, dose, registry number and the like. Appended to this, we have attached a receipt of delivery. All narcotics are issued only

# MERCK PRESCRIPTION CHEMICALS

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**P**HARMACISTS' hands—experienced hands! Every day, everywhere, the hands of experienced pharmacists reach more often for bottles of Merck Prescription Chemicals than for any other brand.

Habit has something to do with it, of course, because habit is, as it were, a second nature. And the containers themselves encourage frequent use because they are attractive, uniform, practical, and convenient to handle.

But after all, the real reason for this widespread and growing preference for Merck Prescription Chemicals among American pharmacists may be summed up in a single word—*Confidence*. They know that the Merck label is a guaranty of purity and reliability.

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in units of 25 tablets in especially designed containers.

When narcotics are issued to the wards, the narcotic record sheet is filled out showing the date, the ward or the unit receiving the narcotics and their nature. The same information is placed on the receipt of delivery slip. When delivery of this unit of narcotics is made, the person receiving it must sign the receipt of delivery slip; this is detached from the body of the record sheet and is returned to the pharmacy. The head nurse then becomes responsible for the care of those tablets and she is provided a locked space for their storage.

The tablets must be signed for as issued and when the remaining supply is not enough for a twenty-four hour period, the head nurse is privileged to sign the record sheet which shows the disposal of each tablet used and to return it together with the bottle containing the unused tablets

to the pharmacy. The pharmacist checks this sheet against the amount of tablets returned and satisfies himself that the record is complete. He then issues a new unit of tablets and a new narcotic record sheet in exchange for the one completed. The pharmacist then has a complete written record of the disposal of each tablet used.

Through the perpetuation of this exchange system of a completed unit for a new unit the pharmacist has an excellent method of controlling narcotics. Before a new unit is issued to a ward the completed unit must be presented to the pharmacist for observation and filing, thereby eliminating the possibility of hoarding narcotics.

Such a system may be used equally well with hypnotics and it is one that gives the pharmacist, at all times, accurate information as to the disposition and location of all narcotics and hypnotics within the hospital.

considerable period of time. The usual dose is 2000 units intramuscularly, although rarely 10,000 units (1 mg.) is prescribed. When taken orally the effect is less certain and slightly larger doses are needed.

### Heparin

• Schmitz and Fischer in Germany and Charles and Scott in Canada have had success in purifying heparin to such an extent that it can now be used in the human body. Needless to say, many uses have been found for this product.

It has been employed by many workers for blood transfusions, the donor being heparinized with 20 to 40 mg. intravenously. This is sufficient to increase the coagulation time for ninety minutes. The coagulation time of the recipient is entirely unaffected.

Thrombosis of all types has responded to heparin treatment. Holmin and Ploman have had success in treating thrombosis of the central vein of the retina. Murray and Best have had good results in experimental thrombosis in dogs and later reported excellent results in 335 human beings treated for peripheral embolism, splenectomy, post-operative pulmonary embolism and phlebitis. Other workers have had fair results in cerebral thrombosis. It has been suggested for use in all serious and prolonged operations. It is obvious that the utmost care must be taken with hemostasis if heparin is to be used postoperatively.

### Nicotinic Acid

• This pellagra-preventive vitamin, as proved by Elvehjem and his associates working on canine black-tongue and Spies, Cooper and Blankenhorn working with pellagrins, is too new a drug as yet to be thoroughly investigated pharmacologically. It can be said that aside from skin manifestations, such as erythema, there have been no reports of intoxication in human beings. McCrea reports no toxic effect from 20 to 60 mg. per kilogram given parenterally to rabbits. Chen, Rose and Robbins found the dog surprisingly resistant to nicotinic acid. The drug does not irritate tissues when administered parenterally in a 1 per cent solution.

Spies, Gross and Sasaki report that nicotinic acid promptly decreases the excretion of porphyrin in the urine of pellagrins. The porphyrinuria of toxic hepatitis, barbitol poisoning, cirrhosis and catarrhal jaundice is also decreased. This suggests that cases of severe liver poisoning might be benefited by nicotinic acid.

The dosage of this new drug is not definite as yet.

## NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology  
University of Chicago

### Potassium Salts

• Following the work of Camp and Higgins, Rusk and Kenamore and others, which indicated that epinephrine might act in the body by the liberation of potassium ions, several clinicians have been trying  $KC_1$  in the treatment of allergic diseases. Bloom has had good results with  $KC_1$ , 0.3 gm. (gr. V), orally T.I.D. in hay fever, while Rusk and Kenamore have obtained promising results in angioneurotic edema. Bloom believes that the beneficial effects are due to the potassium ion, whereas the earlier workers gave the potassium salts for their diuretic properties. The former author also believes that possibly adrenal dysfunction is involved in allergy.

### Cyclopropane

• This cautiously introduced anesthetic gas is assuming an important place in gas anesthesia.

Anesthesia may be obtained with mixtures containing from 7 to 10 per cent of the gas only, while respiratory arrest may be obtained with from 35 to 50 per cent mixtures of the gas. Induction is pleasant and quick and recovery is equally speedy. While the heart may show extrasystoles under deep anesthesia, this is probably no greater in incidence than when other

potent anesthetic agents are used. Nausea and vomiting are about equal in incidence to those produced by ethylene and much less than those produced by ether. Blood pressure tends to rise slightly or to remain stationary during anesthesia. It is best administered in a closed system by anesthetists trained in that technic.

As with chloroform, the administration of any epinephrine derivative is dangerous during deep cyclopropane anesthesia because of the possibility of ventricular fibrillation.

### Theelin and Estrogen Products

• Some of the many uses for this hormone as given by Mazer, Israel, Servinghaus and others are: (1) to treat uterine hypoplasia; (2) to produce hyperestrinemia in the treatment of severe menopausal syndromes; (3) to treat menstrual skin eruptions and menstrual migraine; (4) to alter the growth of vaginal epithelium as in the treatment of juvenile vulvo-vaginitis and senile vaginitis, and (5) to evoke a pituitary-ovarian response in cases of severe amenorrhea by the use of massive doses.

It should be remembered that this is usually substitution therapy and, unless an acute disorder is being treated, the therapy must be continued for a



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# Monthly News Review

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## National Health Program Transmitted to Congress; Wagner to Sponsor Bill

In a carefully guarded statement, President Roosevelt on January 23 transmitted the National Health Program to Congress and recommended it "for careful study by the Congress." He pointed out that the essence of the program is federal-state cooperation and added that "federal legislation necessarily precedes, for it indicates the assistance that may be made available to the states in a cooperative program for the nation's health."

The aim of the proposals, the President said, is a flexible program. "While the eventual costs of the proposed program would be considerable, they represent a sound investment which can be expected to wipe out, in the long run, certain costs now borne in the form of relief," he stated.

Senator Robert F. Wagner (D., New York) has said that he will introduce a bill to provide the first \$50,000,000 to start the National Health Program, which at its maximum ten years hence would cost about \$850,000,000 a year without any provisions for health insurance and cash indemnity for wage losses. If the reports of Senator Wagner's intentions are correct, it appears unlikely that he is expecting to incorporate any health insurance provisions in his bill.

"Historically health protection came first in the development of social security abroad," Senator Wagner stated in a radio address on January 14. "For us, it remains a wholly unsolved problem in social legislation. At the National Health Conference recently held in Washington, a committee of experts presented a comprehensive and unchallenged statement of our national health needs and a blueprint for congressional action. In the near future, I propose to introduce a bill to carry out their recommendations. The health needs of our people can no longer be ignored."

Meanwhile the temporary commission on a long-range health program of New York State has recommended that further study be given to the health problem and particularly mentioned the desirability of analyzing the use of voluntary hospital and medical insurance programs. The commission also recommended further study of the expansion

of governmental health services to meet special problems of pneumonia, cancer, tuberculosis and syphilis control.

In his message to the legislature, Governor Herbert H. Lehman of New York recommended that the legislature appoint a commission to study the whole problem of medical service. Such a commission should include public health experts and physicians as well as legislators, the governor suggested.

During the month the American Public Health Association released a statement of its position on the National Health Program. It stated that it is "certainly theoretically desirable that a single state agency should be made administratively responsible for carrying out all of the provisions of the National Health Program which may be enacted into law." This single agency, the association stated, should be the state department of health with adequate "counsel of qualified advisers from the medical, dental, nursing, hospital and ancillary professions."

Wide latitude should be allowed the states in the definition of the population to be served, methods of serving it and method of raising funds. The association urged that recommendations 1, 2 and 3 of the program, relating to public health activities, should be given priority. It recommended the complete integration of health services of the federal government under one cabinet officer, preferably a secretary of health.

### Will Double Its Capacity

Northwestern Hospital, Minneapolis, will be replaced by a new modern structure and what is known as the middle building will be remodeled shortly in a new building program totaling \$500,000. The improvements will double the hospital's capacity. Plans are under way for a campaign to provide the needed funds.

### Adopts New Name

East Orange General Hospital became the official name of the Homeopathic Hospital of Essex County, East Orange, N. J., it was announced by the board of trustees.

## New Religious Community to Serve Catholic Missions

A new religious community called the Daughters of Mary, Health of the Sick, has been founded for the special purpose of giving medical aid to the Catholic missions. The Motherhouse is at Cragmoor, N. Y., on the 385 acre estate of the late George Inness Jr., renamed Vista Maria. The Sisters also have a residence at 8 and 10 West 17th Street, New York, from which quantities of surgical instruments, medicines, bandages and dressings are purchased or received from all parts of the country and are packed for shipment to missions all over the world.

Some of the members of the new community will volunteer to become nurses, physicians and surgeons, not to engage in foreign practice but to serve as teachers of native women. These native women will be trained to become nurses and, later, doctors, so that they may go into the homes of the people and teach them how to live hygienically.

One of the 12 residences at Vista Maria has been equipped and opened as a Hospice of Rest and Health for convalescents. The Motherhouse will, therefore, serve the United States as well as the missions. Slum areas and remote rural districts that are destitute medically will be a part of the work of this new community.

Rev. Edward F. Garesché, S.J., president of the Catholic Medical Mission Board, was the originator of the idea of the new medical and nursing community.

### Trustee Kidnapped, Robbed, Freed

Within a few minutes after being elected vice president of the board of trustees of New Jersey Orthopedic Hospital, Orange, N. J., Brian P. Leeb, West Orange, banker, found himself elected as victim of three Negro robbers who kidnapped him from in front of the hospital. He was forced to drive the trio away from the hospital, was robbed of \$27 and his watch and was then freed, unharmed, on a deserted mountainside in West Orange. Mr. Leeb was accosted when he returned to the hospital after driving Raymond P. Sloan, associate editor of *The Modern Hospital*, to the train. Mr. Sloan was guest speaker at the trustees' meeting.



## Saves Hundreds of Injections Yearly

● Protamine, Zinc & Iletin (Insulin, Lilly) apparently represents a step forward in the management of diabetes. Its prolonged action makes it possible to effect a saving of hundreds of injections a year in severe cases.

In order that the physician may have his choice, pharmacists should maintain adequate stocks of Protamine, Zinc & Iletin (Insulin, Lilly) in 10-cc. vials, 40 units per cc., 10-cc. vials, 80 units per cc., and of Iletin (Insulin, Lilly) in its various strengths and sizes.



# ELI LILLY AND COMPANY

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## Voluntary Hospitals of New York and Insurance Companies Settle Argument

The long controversy between the voluntary hospitals of New York City and the insurance companies was finally settled just before the new year by a preliminary agreement fixing a compromise rate of \$5.25 a day for workmen's compensation cases. In addition to this, the agreement covers special charges for other services, such as \$10 for the operating room without anesthesia and \$15 with anesthesia for a major operation.

The agreement also provides that a standard form for reports shall be worked out and then sent to hospitals with the sum of \$1.50 as a fee. The hospitals agreed to show x-ray films to authorized physicians representing the companies and to accept mailed subpoenas accompanied by a fee of \$1.50. An arbitration procedure was set up to handle disputes. The agreement was accepted by the state insurance commis-

sioner and the state industrial commissioner.

In January, the United Hospital Fund prepared a memorandum to the city government requesting that the city payments for the care of patients in voluntary hospitals should be increased by about \$2,000,000. Under the new schedule the voluntary hospitals would receive from the city about \$7,500,000 for providing service to city charges which cost about \$11,700,000, leaving a net loss to the hospitals on this work of \$4,200,000.

The combined deficit of hospitals which are members of the fund has been \$2,000,000 annually for the last three years. The hospitals anticipate that their deficits will increase because they will shortly be forced to adopt an eight hour day, to pay better wages and to bring their employees under the Social Security Act.

## Three Hospitals Benefit Through Generous Gifts

Three hospitals that have recently received sizable gifts or bequests are the John Sealy Hospital, Galveston, Tex., Michael Reese Hospital, Chicago, and the Muhlenberg Hospital, Plainfield, N. J.

Dr. Edward Randall, chairman of the board of John Sealy Hospital, announced that the will of Mrs. Jennie Sealy Smith, who died on Oct. 10, 1938, directed that, after the payment of certain bequests, the balance of her estate, estimated at \$4,000,000, be left to the Sealy and Smith Foundation for the John Sealy Hospital. A private and semiprivate pavilion is to be erected in memory of her husband, R. Waverly Smith.

The bequest of Dr. Emanuel Friend to the Michael Reese Hospital, Chicago, for the establishment of a charity home for convalescents will be much larger than was originally estimated. Under the provisions of the will the hospital will receive \$1,170,000.

Two gifts totaling \$240,000 will pay a large part of the cost of the new building program of the Muhlenberg Hospital, Plainfield, N. J. The program calls for the construction of a building to house an operating room pavilion and administration quarters and two story addition to the east pavilion. The operating room floor is being built by a gift of \$150,000 from

Jessie Munger and the new administration floor, by a gift of \$90,000 from Mrs. John Peters Stevens, Mr. and Mrs. John Peters Stevens Jr., and Mr. and Mrs. Robert Van Broeck Stevens and Mr. and Mrs. Nathaniel Stevens.

## Michigan Doctors Plan Insurance

The Michigan State Medical Society last month passed resolutions authorizing its council to proceed with the formation of a hospital care insurance plan and a medical care insurance plan, the former to be formed in collaboration with the Michigan Hospital Association as well as various industrial, agricultural and other consumer groups. The council also was authorized to use its judgment regarding the introduction of necessary legislation. Ward and semiprivate hospital use is proposed for the insured groups.

## New Arts Nursing Course in Maine

Three of Maine's largest hospitals are cooperating with the University of Maine in presenting a five year course in liberal arts and nursing, which will lead to a bachelor of arts degree and a hospital diploma. Hospitals working with the university on the plan, designed to relieve the shortage of public health nurses, are Maine General Hospital, Portland; Central Maine General Hospital, Lewiston, and Eastern Maine General Hospital, Bangor.

## Bellevue Hospital Reports Clinical and Administrative Progress

Important administrative and clinical advances at Bellevue Hospital, New York City, were reported by Dr. S. S. Goldwater, hospital commissioner, in a statement to the mayor.

A systematic course of instruction for ward maids and orderlies has been started; the metric system has been adopted for all medications and solutions; the use of metrazol for schizophrenia, of insulin in other psychiatric cases, and of sulfanilamide in a variety of other cases has shown promising results; the blood bank opened in July has expedited blood transfusion service and decreased the need for professional donors.

A new dietetic manual has reduced the number of special diets from 77 to 12; the administration of cod liver oil has speeded healing of diabetic ulcers and bed sores; special studies of pneumonia and its treatment with a sulfanilamide derivative show great promise. Construction work was recently started on the new administration building which, when completed, will round out a building program begun 40 years ago with Doctor Goldwater as consultant.

## New Drug Therapy for Pneumonia

The new derivative of sulfanilamide, officially named sulfapyridine, was recently declared to be "a more hopeful chemotherapeutic agent so far to be discovered for the treatment of all types of pneumonia." Reports on its use in various New York hospitals were presented at a meeting at the New York Academy of Medicine on January 17. When combined with serum therapy, it promises to reduce the present mortality from pneumonia by as much as 66 per cent, it was stated. Reports on its use in England also were presented at the meeting.

## Kodiak to Have Hospital

Work has started on a \$37,000 hospital for Kodiak, Alaska. It will serve the area from Unimak at the tip of the Alaska Peninsula to Seward on Resurrection Bay. The structure will be of reinforced concrete, two stories high, and will have 18 beds. Citizens of Kodiak and near-by communities have subscribed to a fund of \$5000 for furnishing and equipping the hospital, which should be completed by the last of February.

# IN SURGICAL EMERGENCIES



**I**N ACUTE lowering of the blood pressure due to trauma, hemorrhage, spinal and general anesthesia, or shock, several advantages are afforded by the use of

ONE PER CENT STERILE SOLUTION OF

## NEO-SYNEPHRIN Hydrochloride

(laevo-alpha-hydroxy-beta-methyl-amino-  
3-hydroxy ethylbenzene hydrochloride)

The pressor effect which follows the subcutaneous injection of Neo-Synephrin Hydrochloride is not only promptly produced but long sustained.

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Neo-Synephrin Hydrochloride is less toxic in therapeutic dosage than either epinephrine or ephedrine.

Average subcutaneous dose: 0.5 cc.



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## 2 1/2 Million Persons Take Out Hospital Insurance Yearly

Nearly 2,875,000 persons were covered as subscribers or their dependents by hospital care insurance plans on January 1, according to data compiled by C. Rufus Rorem, director, committee on hospital service of the American Hospital Association. Reports were received from the 41 approved plans and 12 other plans that had been approved as to form of organization.

This represents an increase of 625,000 persons covered since the previous tabulation on October 1 and an increase at the rate of 2,500,000 persons per year.

Enrollment in some of the large plans on January 1 was as follows: New York City, 1,081,000; Minnesota, 245,000; Cleveland, 154,000; Boston, 116,000; New Jersey, 111,000; Rochester, N. Y., 109,000; Chicago, 85,000; Syracuse, N. Y., 67,000; Pittsburgh, 65,000; New Haven, Conn., 61,000; St. Louis, 51,000; Washington, D. C. (estimated), 50,000; Buffalo, 49,000; Alabama, 42,000; New Orleans, 40,000; Philadelphia (estimated), 37,000; Baltimore, 32,000.

## Kansas City Has First Gray Ladies

Graduation exercises were held January 11 for 19 Gray Ladies of Menorah Hospital, Kansas City, Mo., the first unit in that city. The certificates presented the young women signified that they had completed a fifteen hour course offered by the hospital staff to qualify for hospital and recreational service under the American Red Cross. The Gray Ladies pledge themselves to fifty-two hours' service a year. Their work includes reading to patients, shopping for them and similar tasks.

## Oklahoma Names Officers

Hospital insurance, rates charged to insurance companies and hospital lien laws were discussed at the annual meeting of the Oklahoma State Hospital Association held in Oklahoma City, December 15 and 16. New officers elected by the group were: Dr. E. T. Olsen, superintendent of the University Hospital, Oklahoma City, president; Roy Alexander, credit manager, Morningside Hospital, Tulsa, vice president, and H. Albert Taylor, superintendent of El Reno Sanitarium, El Reno, secretary-treasurer.

## Children's Memorial, Chicago, to Erect Tenth Unit of Plant

The Children's Memorial Hospital, Chicago, expects to break ground in the spring for a new clinic building comprising four stories and basement. The building is made possible through a gift made in 1935 by Gwethalyn Jones in memory of her uncle, Thomas D. Jones, president of the board of trustees from 1914 to 1927.

The new clinic will be built on the site of the present Cribside, three story infants' pavilion on Orchard Street, and will house examining rooms, record room, pharmacy and hospital admitting unit. One wing will be devoted to the x-ray, basal metabolism, electrocardiograph and photographic departments. This unit will be located at a point at which it can serve hospital patients as well as clinic cases and yet keep both groups completely segregated.

## Health Program to Be Concern of Western Hospitals Meeting

The Association of Western Hospitals, meeting jointly with the western conference of the Catholic Hospital Association and allied organizations, will convene in Seattle, Wash., Feb. 19 to 23.

Prepayment plans for both medical and hospital care, plans for adequate care of those who cannot afford to pay and must be cared for by governmental agencies and the National Health Program will be considered from the point of view of hospital participation.

Among the speakers are: Dr. Malcolm T. MacEachern, Dr. G. Harvey Agnew, Dr. R. C. Buerki, Dr. G. O. Whitecotton, Dr. B. W. Black, C. Rufus Rorem, R. E. Heerman, Ellard L. Slack, Dr. Paul I. Carter and Ralf Couch. George U. Wood will present his motion picture, previewed in last month's issue of *The Modern Hospital*.

A trustees' section, presided over by Samuel M. Jackson, president of the board of Tacoma General Hospital, Tacoma, Wash., will be held, with Doctor MacEachern as chief speaker.

## New Clinic for Mount Sinai, Chicago

At the annual meeting of Mount Sinai Hospital, Chicago, President Morris Kurtzon announced that plans are being formulated for the erection of a clinic building adjoining the hospital, designed to give service to 250 underprivileged ambulatory patients daily.

## Coming Meetings

1939

- Jan. 18-20—Sectional Meeting, American College of Surgeons (Tennessee, Arkansas, Mississippi, Alabama, Georgia, Florida, Kentucky, Louisiana), Andrew Jackson Hotel, Nashville, Tenn.
- Jan. 23-28—Minnesota Institute for Hospital Administrators, University of Minnesota, Minneapolis.
- Feb. 13-14—Annual Congress of the Council on Medical Education and Hospitals of the American Medical Association, The Palmer House, Chicago.
- Feb. 19-23—Association of Western Hospitals, Seattle, Wash.
- Feb. 20—Oregon Association of Hospitals, Olympic Hotel, Seattle.
- Feb. 20-23—Association of Western Hospitals, Seattle.
- March 9-11—New England Hospital Association, Hotel Statler, Boston.
- Mar. 15-17—Sectional Meeting, American College of Surgeons (Maryland, Virginia, District of Columbia, New Jersey, Delaware, Eastern Pennsylvania, North Carolina, South Carolina), Lord Baltimore Hotel, Baltimore.
- Mar. 22-24—Sectional Meeting, American College of Surgeons (Indiana, Illinois, Michigan, Ohio, Iowa, Wisconsin), Indiana Claypool Hotel, Indianapolis.
- Mar. 29-31—Sectional Meeting, American College of Surgeons (Manitoba, Alberta, Saskatchewan, Northern Ontario, Minnesota, North Dakota, South Dakota), Fort Garry Hotel, Winnipeg, Man.
- April 11-13—Ohio Hospital Association, Deshler Hotel, Columbus.
- April 13-15—Southeastern Hospital Conference (Florida, Georgia, Alabama, Mississippi, Louisiana), Roosevelt Hotel, Jacksonville, Fla.
- April 20-22—Carolinas-Virginia Hospital Conference, Roanoke Hotel, Roanoke, Va.
- April 20-21—Mid-West Hospital Association, Hotel Eastman, Hot Springs, Ark.
- April 21-22—Texas Hospital Association, Fort Worth, Tex.
- April 24—National League of Nursing Education, New Orleans.
- April 24—Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church, Kansas City, Mo.
- April 24-26—Iowa Hospital Association, Cedar Rapids.
- April 26-28—Hospital Association of Pennsylvania and Pennsylvania Association of Nurse Anesthetists, Bellevue-Stratford Hotel, Philadelphia.
- May 3-5—Tri-State Hospital Assembly, Stevens Hotel, Chicago.
- May 3-5—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.
- May 8—Mississippi Hospital Association, Gulfport.
- May 15-19—American Medical Association, St. Louis.
- May 17-19—Hospital Association of New York State, Hotel Pennsylvania, New York City.
- May 25-27—Minnesota Hospital Association, St. Paul.
- June 1-4—National Executive Housekeepers Association, William Penn Hotel, Pittsburgh.
- June 8-10—New Jersey Hospital Association, Hotel Dennis, Atlantic City, N. J.
- June 18-24—American Association of Medical Social Workers, Buffalo, N. Y.
- June 22—Manitoba Hospital Association, Winnipeg, Man.
- June 25-28—American Sanatorium Association, Boston.
- July 31-Aug. 12—Southern Institute for Hospital Administrators, Duke University, Durham, N. C.
- Aug. 13-15—National Hospital Association, New York City.
- Aug. 27-Sept. 1—American Dietetic Association, Ambassador Hotel, Los Angeles.
- Sept. 11-15—American Congress on Obstetrics and Gynecology, Cleveland.
- Sept. 19-23—International Hospital Association, Toronto, Ont.
- Sept. 21-22—Canadian Hospital Council, Toronto.
- Sept. 24-25—American College of Hospital Administrators, Toronto.
- Sept. 25-29—American Hospital Association, Toronto.

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# Names in the News

## Administrators

DR. A. F. YOUNG, superintendent of the Hospital for Mental Diseases, Wauwatosa, Wis., a unit of the Milwaukee County Institutions, retired recently. DR. MICHAEL KASAK, clinical director for the Hospital of Mental Diseases and the Asylum for Chronic Insane, of which Doctor Young also was acting director, has taken over Doctor Young's duties at the two hospitals temporarily. A permanent successor will be chosen after a civil service examination.

DR. NEAL N. WOOD, field director of the Chicago Medical Society, has been appointed administrator of the Pierce County Hospital, Tacoma, Wash., succeeding DR. BURTON A. BROWN, whose resignation from the institution will take effect not later than April 1.

BARBARA A. HUNTER, for the last ten years superintendent of the Little Falls Hospital, Little Falls, N. Y., has been appointed head of Potsdam Hospital, Potsdam, N. Y. She replaces Mrs. EVA T. NILES, who administered the hospital for thirteen years.

DR. CHARLES R. SCOTT, Twin Falls, Ida., has been appointed superintendent of the State School and Colony for the feeble-minded at Nampa, Ida., to succeed DR. D'ORR POYNTER.

DR. ARTHUR J. GAVIGAN has been appointed assistant superintendent of Medfield State Hospital, Harding, Mass. Doctor Gavigan is a graduate of Yale University medical school.

CLARICE N. LUNDREN, R.N., Bangor, Me., has been appointed superintendent of the Mayo Memorial Hospital, Dover Foxcroft, Me., to succeed NELLIE C. DYSART, R.N., who was married recently to DR. OSCAR NORELL of Caribou, Me.

ANTHONY W. ECKERT succeeded GEORGE W. MORROW as superintendent of Fitkin Memorial Hospital, Neptune, N. J., on January 1.

A. EDWARD A. HUDSON, former administrator of the Waynesboro Community Hospital, Waynesboro, Va., became superintendent of the El Paso Masonic Hospital, El Paso, Tex., on January 1.

ERNEST G. MCKAY, recently elected superintendent of Tampa Municipal Hospital, Tampa, Fla., began his new duties February 1. Mr. McKay was

for ten years superintendent of Arnot-Ogden Memorial Hospital, Elmira, N. Y.

DR. WILLIAM C. INMAN, director of clinical psychiatry, Danvers State Hospital, Hathorne, Mass., has been transferred from that position to that of assistant superintendent of the hospital.

JEANETTE TAYLOR, graduate of the Methodist Hospital, Indianapolis, Ind., is the new superintendent of the Union Hospital, Dover, Ohio. She was for two years anesthetist at St. Luke's Hospital, Chicago. Miss Taylor takes the place of MARY GELSER, who resigned some months ago.

DR. A. A. FOOTE has taken over the management of the Conway Hospital, Elma, Wash. ANN MULLIGAN, superintendent of the Aberdeen General Hospital, Aberdeen, Wash., for several years, has resigned and will serve in the same capacity at Conway Hospital.

MRS. SILAS B. CLARK, who has served as superintendent of the Moses-Ludington Hospital, Ticonderoga, N. Y., for the last year, has relinquished her duties. She has been succeeded by MARTHA WETHERLY R.N.

GRACE E. ALLISON, R.N., who resigned the superintendency of the Samaritan Hospital, Troy, N. Y., on December 28, has been given the title of honorary superintendent.

JOHN KENNEY, who resigned as superintendent of the Washoe County Hospital, Reno, Nev., some months ago as the result of a reported dispute with the hospital board, was recently reinstated as superintendent of the institution by a new board. A. R. LONGFIELD, who had been acting superintendent, will continue as office manager.

GLEN W. FAUSEY has resigned as superintendent of the Pontiac General Hospital, Pontiac, Mich., to assume the superintendency of the Edward W. Sparrow Hospital at Lansing, Mich. Mr. Fausey was formerly connected with Highland Park General Hospital and the Henry Ford Hospital in administrative positions. ADELAIDE NORTHAM, R.N., whom Mr. Fausey is succeeding, has left the Edward W. Sparrow Hospital after a term of twelve years to do some special work at Duke University.

MARGARET MAYES has been named superintendent of the children's de-

partment of Memorial Hospital, Johnstown, Pa., to succeed FRED A. ROSEMAN, who resigned to accept a similar position at Lynchburg, Va. Miss Mayes served as assistant supervisor and later supervisor of the children's department of the Philadelphia General Hospital, from which she was graduated in 1935.

DR. C. M. SHARP has been appointed superintendent of the State Tuberculosis Sanatorium at Alto, Ga.

MARGARET SPIERS succeeds JANET CURRIE as head of the General Hospital, Bay City, Mich. Immediately prior to her new appointment, Miss Spiers was superintendent of Clinton Memorial Hospital, St. Johns, Mich.

## Trustees

CHICHESTER C. KERR has been appointed president of the board of trustees of the New Jersey Orthopedic Hospital and Dispensary, Orange, N. J. Mr. Kerr, who formerly was chairman of the executive committee, succeeds THEODORE MCCURDY MARSH, who retired after eight years as president. Other new officers named were: vice president, BRIAN P. LEEB; secretary, Mrs. FRANKLIN RYAN FORT, and assistant secretary treasurer, Mrs. CLARA JACOB BOLL. WILBUR MUNN, treasurer for four years, was reelected.

DR. GRACE N. KIMBALL was reelected president of the board of trustees of the Samuel Bowne Memorial Hospital, Poughkeepsie, N. Y. All other officers of the board were also reelected.

FEDERAL JUDGE T. M. KENNERLY is retiring as president of the Memorial Hospital, Houston, Tex., after twenty years of service in that position. He will serve as president emeritus for life. J. W. NEAL is the new president.

DR. D. A. CRIST was elected president of the board of the Good Samaritan Hospital, Dayton, Ohio, at the annual meeting of the staff. Doctor Crist is chief of staff of the hospital.

HARRY PELHAM ROBBINS, president of Memorial Hospital, New York, since 1933, was reelected at the annual meeting. Others serving with him are WALTER DOUGLAS, chairman of the board, and H. MORTON HARRIMAN, secretary. CHARLES H. SIMMONS was elected vice president and EDWARD C. DELAFIELD, treasurer.

DAVID E. WILLIAMS JR., a member of the board of managers of the Pennsylvania Hospital, Philadelphia, since 1929, has been elected president of the hospital, succeeding ARTHUR V. MOR-



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January 1939\*

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\*Excerpt from article by David J. Cohn, Ph.D., Director, Department of Bio-chemistry, Michael Reese Hospital, Chicago—pg. 76, Modern Hospital, January, 1939.

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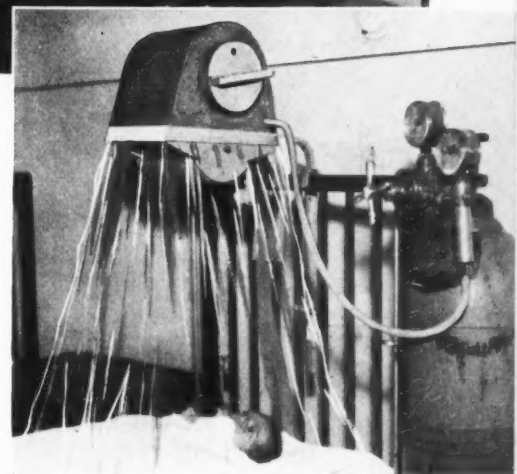
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TON, who resigned after serving fifteen years. SYDNEY P. CLARK has been elected vice president of the hospital.

DR. AUGUSTUS S. KNIGHT was re-elected president of the board of trustees of Somerset Hospital, Somerville, N. J., recently.

#### Miscellaneous

DR. BENJAMIN B. LENNON has accepted the position of director of the department of anesthesia at Michael Reese Hospital, Chicago.

HELEN BECKLEY has resigned as director of the social service department of Cook County Hospital, Chicago, to become executive secretary of the health division of the San Francisco Council of Social Agencies.

MARY ROBERTS, formerly of Holyoke, Mass., has become director of the social service department at Orange Memorial Hospital, Orange, N. J.

RUTH COOPER, director of the social service department, Los Angeles County General Hospital, Los Angeles, has resigned her position and is studying at the University of Chicago.

#### Deaths

DR. JOHN T. BRENNAN, superintendent of the Jackson County Emergency Hospital, Little Blue, Mo., died recently following a heart attack. He had been Jackson County health commissioner for twelve years.

DR. DONALD GREGG, head of the Channing Sanitarium, Wellesley, Mass., died January 6 at Phillips House following a short illness. He had been associated with the sanitarium for twenty-five years.

#### Maffly Heads East Bay Group

Alfred E. Maffly, superintendent of the Berkeley General Hospital, Berkeley, Calif., recently was elected president of the East Bay Hospital Conference, succeeding Ellard L. Slack, superintendent, Samuel Merritt Hospital, Oakland, Calif. Mr. Maffly has been secretary of the Hospital Conference for the last four years. Other new officers are: Florence Klaeser, East Oakland Hospital, Oakland, Calif., vice president, and John Rafter, Richmond Cottage Hospital, Richmond, Calif., secretary-treasurer.

#### Italian Society Has Hospital

The Italian Hospitalization Society, founded in 1937, has taken over the Parkway Hospital, New York. The hospital will be a community institution supported by the society.

### Surgeon General's Report Shows Striking Progress in Public Health Ideals

A greater advance has been made in public health in the United States during the last two years than ever before within a comparable period, according to the 1938 annual report of Surgeon General Thomas Parran.

The outstanding recent developments, Doctor Parran states, are those resulting from the government's increasing assumption of responsibility to the country in health matters and the practical interpretation of these new ideals and goals by such recent acts of Congress as the Venereal Disease Control Act and the National Cancer Institute Act.

In closing his report, the surgeon general recommended, among other things, the establishment in the National Institute of Health of a unit for wider chemotherapy investigations, additional funds under the Venereal Disease Control Act and the establishment of a neurological institute for laboratory and clinical investigations of mental and nervous diseases.

#### Missouri Convention at Columbia

The 1939 convention of the Missouri Hospital Association will be held on Tuesday and Wednesday, February 7 and 8, in Columbia, Mo., at the Tiger Hotel. Speakers on the program for Tuesday will include Ray F. McCarthy, director of the Group Hospital Service, Inc., of St. Louis, and Bert W. Caldwell, M.D., executive secretary of the American Hospital Association. On Wednesday Malcolm T. MacEachern, M.D., will conduct a round table discussion.

#### Major Stimson Is Speaker

The annual luncheon of the Central Council of Nursing Education will be held Monday, February 13, in the grand ballroom of the Palmer House, Chicago. The speaker will be Major Julia C. Stimson, president of the American Nurses' Association and retired superintendent of the U. S. Army nurses' corps.

#### Work Begun on Veterans' Hospital

The federal government has begun excavating on a 244 acre tract recently acquired in Dallas, Tex., as the site of the new \$1,200,000 veterans' hospital. The ten building plant is being constructed with P.W.A. funds.

#### Philanthropy Favors Health Field

Philanthropists gave or bequeathed more for health and hospitals during 1938 than during 1937, despite the business recession, according to a survey by the John Price Jones Corporation. Gifts and bequests for health were \$14,339,730 in the six largest cities in 1938 as compared to \$8,649,762. Sharp declines in gifts to education and organized relief were noted during last year. Foreign relief also decreased.

#### Institute for Nurse Administrators

An institute for directors of schools of nursing and nursing services will be held on June 15 to 17 in Judson Court, University of Chicago. Copies of the program will be available in April from the nursing education office of the university.

The institute is planned primarily for those engaged in nursing administration but will be open also to nurse educators.

#### Seek Funds to Buy Hospital

A financial campaign for \$100,000 for the purchase and improvement of the Lake View Hospital, Chicago, began on January 24. Negotiations are already under way for the sale of this private institution to a corporation of community leaders who are to make it a community enterprise. The name of the hospital has been changed to Lake View Community Hospital.

#### W.P.A. Projects Aid Three N. Y. Municipal Institutions

Three New York City hospitals—Kings County, Cumberland and Greenpoint—benefitted by Works Progress Administration labor and funds during the first month of 1939. Work was begun on the fabrication and installation of more than 4600 new bronze screens for the windows, skylights, porches and doors of Kings County Hospital as a protection against insects for the hospital's large resident population. The project will cost approximately \$84,925, one-fifth of the expense being borne by the city.

Redecoration of approximately 750,000 square feet of the Greenpoint Hospital, including the main structure, employees' buildings, morgue and garage was begun the middle of the month.

At the request of Dr. S. S. Goldwater, emergency repairs to the storm-damaged roofs of Cumberland and Kings County Hospitals were made.

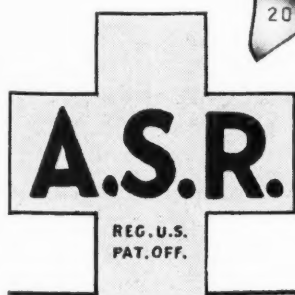


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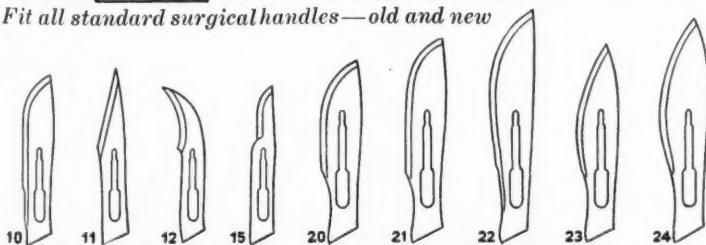
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# LITERATURE *in* ABSTRACT

Conducted by E. M. Bluestone, M.D., and William B. Talbot, M.D.

## Oxygen Therapy

Indications for oxygen therapy must be carefully considered so as to avoid still further conflicting evidence as to its value.\* Cyanosis resulting from localized consolidation or collapse can seldom be relieved by oxygen. Anoxemia resulting from generalized impairment of aeration or from a diffuse inflammatory process can be improved by oxygen therapy. An adequate supply of oxygen can be assured by the use of a flowmeter, in conjunction with a reducing valve.

Various methods of oxygen therapy must be considered from the points of view of (1) efficiency, (2) comfort, (3) ease of operation, (4) economy and (5) necessity for cooperation on the part of the patient. The administration of oxygen intravenously, subcutaneously or per rectum has no rational basis. The most satisfactory technics are the nasal catheter, the nasal mask and the oxygen tent. The nasal catheter is often too uncomfortable for continuous use in adults, although it may be satisfactory in infants. The nasal mask is efficient, comfortable and inexpensive. There is described here a new simple comfortable rubber mask. The oxygen tent is comfortable and efficient but is expensive and requires expert supervision. The oxygen chamber is the ideal medium for oxygen therapy, but its cost is almost prohibitive.

\*Christie, Ronald V., M.D.: Oxygen Therapy, *Lancet*, Oct. 15, 1938. Abstracted by J. Masur, M.D.

## Finding Lost Radium

Loss of radium is a frequently recurring problem. In the evolution of methods used in its recovery the electroscope has been replaced by the Geiger-Muller counter. This is an instrument capable of measuring extremely small amounts of the radiation emitted by radio-active substances.

The author\* has developed two portable counters, one of which is operated on alternating current, the other on batteries. Measurements were made with radium enclosed in a brass capsule and placed in an empty lot. Under these conditions 50 mg. of radium could be detected up to a distance of 212 feet, whereas 1 mg. could be detected up to 30 feet. Immersed in water 50 mg. of radium could be detected up to 70

inches, whereas 1 mg. could be detected up to 36 inches. This, however, represents a conservative estimate of the detection powers of the instrument because only the most decisive criteria were used in the results quoted.

\*Taft, Robert B.: Further Observations Concerning the Recovery of Lost Radium, *Radiology* 31 (Sept.) 1938. Abstracted by Henry Potozky, M.D.

## Dental Internships

One of the principal factors in the further development of the clinical relation of dentistry to systemic diseases, and one that has not been developed to its full potentiality, is that of intern service preparatory to the practice of dentistry. Various benefits may be derived from dental internship:\* (1) education of dental and medical interns along parallel lines; (2) protection from disease and shortened convalescence when the mouth of the hospital patient is kept in a healthy condition; (3) benefits in diagnosis and treatment when close relationship of the medical intern with the dental intern is maintained; (4) value to the graduate dental student and to dentistry through the practice of gathering statistics and the making and studying of case records.

A definite effort is being made by the American Dental Association to enlarge the opportunities for dental internship and at present there are 120 hospitals throughout the country offering 180 internships. There are also 54 internships available in the U. S. marine hospitals and in the penitentiaries. The time is not far off when compulsory dental internship will be a requisite for dental practice. The internship may be instrumental in evolving the dental graduate into an efficient unit in the community health service.

\*Anthony, L. Pierce: Dental Internship, *J. Am. D. A.*, November 1938. Abstracted by David Tanchester, D.D.S.

## How to Paint Brick

Owing to the marked increase in the painting of brick structures, both new and old, the following points are useful.\*

The surface should be carefully inspected. If old, it may require scraping, pointing up, removal of dirt and dust, and it may have to be reprimed, if

previously painted. If it is a new surface recently constructed, it may be necessary to neutralize the active alkali in the mortar between the bricks by washing the surface with a solution of zinc sulphate. Usually 2 pounds to a gallon of water is sufficient.

In any case not only must the surface be very dry but, because of the fact that brick is very absorbent to moisture, it is necessary that there has been no water on the surface for at least a week or ten days before the priming coat is put on.

After ascertaining that the surface and porousness of the brick are undisturbed, careful selection of paint of good quality and proper application of it should ensure a satisfactory result.

\*Dutch Boy Quarterly 16: 3, 1938. Abstracted by William B. Talbot, M.D.

## State and Medical Research

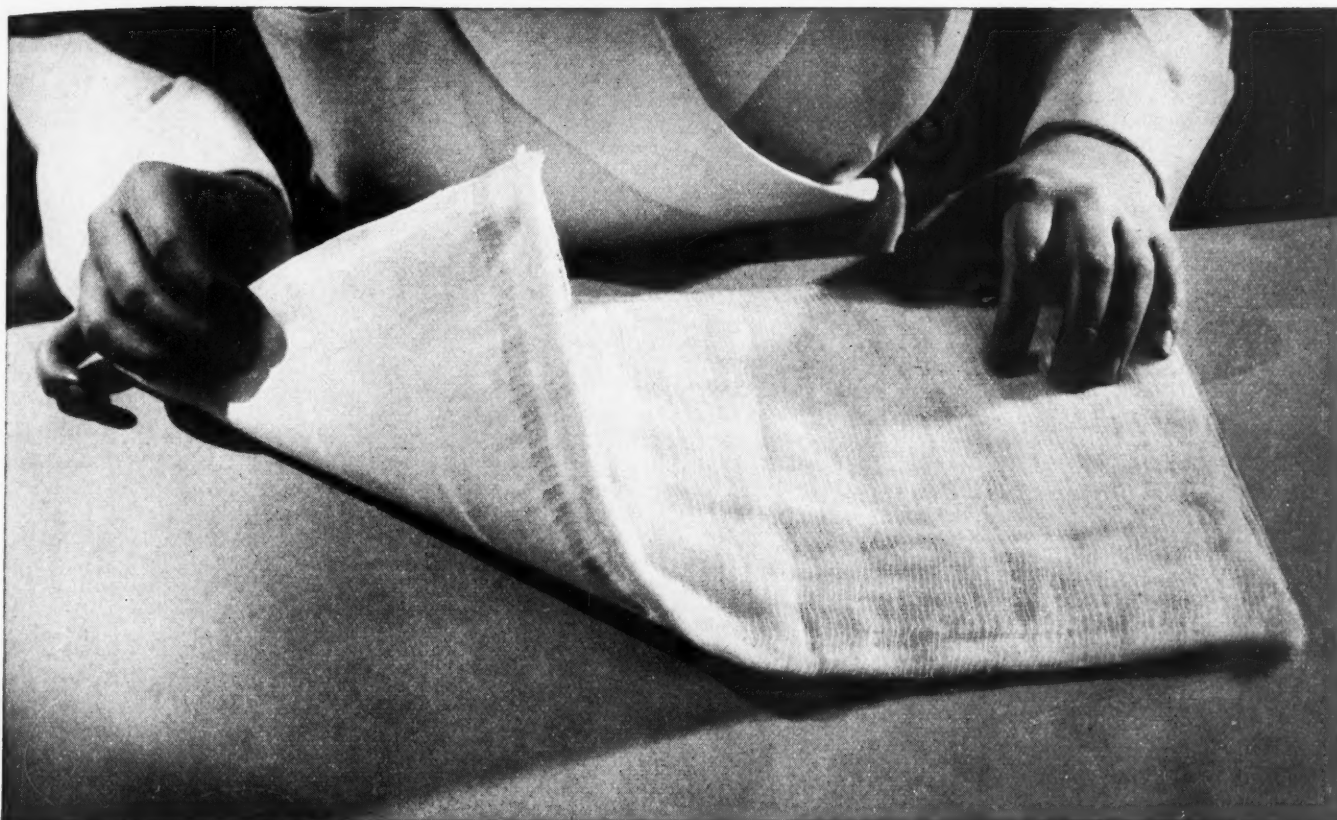
Private endowment of research in medicine or industry in England is meager compared to the large foundations supporting this project in the United States. The Rockefeller Foundation has stimulated some response. The Nuffield scheme at Oxford is possibly an indication that in the future private persons will be more likely to support research as well.

Failing in private support, the state must endow research.\* State control of medical research can be compatible with freedom to the investigator and there are acceptable ways in which state funds may be used for the purpose of promoting discovery in medicine. In 1913 the British government set up the Medical Research Council under the terms of the National Health Insurance Act. In 1920 the arrangement was changed to an independent body with direct support from Parliament.

The Medical Research Council has been singularly free of any political influence through the careful choice of its constituent members. The constant change in the personnel of the council with members being appointed for only four year terms tends to prevent any dictatorship of ideas. For the most part financial support is given to good work, but occasional work of doubtful quality is supported until the true value is appreciated. In either case the views are those of the investigators.

For general guidance the council relies on the advice of 27 special committees of 60 members who are specialists in the respective fields of medicine and related sciences. The services of these committees are given voluntarily and their membership is of outstanding rank. The state grants almost





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## DIAPERS

\$1,000,000 yearly to the council for its work. The sum is revised every five years. In addition to the state fund, the council controls \$600,000 yearly of private funds.

The money is expended in three main directions:

1. The National Institute for Medical Research, which plans large scale, long term work of a nature not suitable for university or hospital laboratories. In addition to research in the preclinical sciences, it standardizes biologicals, vitamins and hormones.

2. It places units of research in the different institutions, both clinical and laboratory. The council pays the salary and the cost of research. The university or hospital supplies the facilities.

3. The allocation of personal grants to individuals and of research fellowships for travel abroad.

\*Mellanby, Sir Edward: The State and Medical Research, *Lancet*, Oct. 22, 1938. Abstracted by Leonard Tarr, M.D.

## Rheumatism in Scotland

This article\* is one of a series of valuable reports published by the scientific advisory committee of the Empire Rheumatism Council representing a continuation of the work of the British committee on chronic rheumatic diseases.

One-sixth of the total invalidity of insured persons annually in England is due to rheumatic diseases. Therapeutic facilities are totally inadequate. The economic loss is estimated at \$100,000,000. The present study of the problem in Scotland indicates that, in 1936, among the third of the population carrying health insurance, rheumatic diseases caused 14 per cent of total invalidity at an economic loss of more than \$10,000,000. No official figures are available for the remaining two-thirds of the population, but the authors' attempt to estimate the incidence suggests a tremendous number of cases. The facilities for the treatment of rheumatism in Scotland are wholly inadequate, particularly in the field of physical therapy.

The magnitude of the problem is such that the voluntary hospital has been and will be unable to care for even advanced cases, to say nothing of instituting early treatment. Physical therapy departments are inadequate and there is need for physicians trained for the diagnosis and treatment of rheumatism. Ignorance and apathy of the medical profession in regard to the national importance of rheumatism are deplored.

The establishment of centers situated throughout the country with an ade-

quate number of properly trained specialists and the enlargement of existing institutions should be provided by the national government.

\*Davidson, L. S. P., and Duthie, J. J. R.: Can the Voluntary Hospital System Solve the Problem of Rheumatic Disease? Reports on Chronic Rheumatic Diseases, No. 4. Abstracted by J. Masur, M.D.

## Optimum X-ray Voltage

The details of construction of the high voltage x-ray tube now in use at the California Institute of Technology are outlined. This tube can be operated up to potentials of 1200 k.v. It has been used since October 1930 in the treatment of deep-seated malignant tumors. The potential now employed under therapeutic conditions is 900 k.v.

Despite the trend toward higher and higher voltages in modern radiotherapy, a determination of the optimum voltage to be used in deep x-ray is a complicated problem, as yet unsolved. The author\* has made a detailed study of the dosage delivered in the depth with low and high voltage radiations.

In general, the results presented would indicate that there is no one optimum voltage in radiotherapy but rather that the efficiency of a given potential varies, depending on the size of the field and the depth at which the maximum effect is desired. Thus at 10 cm. depth, using very large portals, a tube operated at from 400 to 500 k.v. will give a greater depth dosage than will radiations produced at either lower or somewhat higher voltages.

\*Lauritsen, Charles C.: The Development of High Voltage X-Ray Tubes at the California Institute of Technology, *Radiology*, September 1938. Abstracted by Henry Potozky, M.D.

## Protection From Radium

Handbook No. 18 of the National Bureau of Standards pertaining to radium protection has recently been revised. The advisory committee sponsoring this report consisted of representatives of the International Safety Committee, the American Roentgen Ray Society, the Radiological Society of North America, the American Medical Association, the American Radium Society and x-ray equipment manufacturers.

The handbook\* is divided into eight sections, as follows:

- 1—General Considerations: The need for protection of the radium worker arises from the danger of overexposure to radiation. Constant realization of these dangers by the worker is essential. Distance and brevity of ex-

posure represent his greatest protection. In addition, the laboratory must provide him with protection by adequate lead screenage of radium sources in his vicinity. Charts are presented showing the thickness of lead necessary for adequate protection when the individual is exposed to any given quantity of radium at any given distance. The degree of blackening of photographic dental films carried in a pocket during working hours may be used as a rough test of protection.

- 2—Personnel: The end result of local overexposure is the radium burn. Periodic examination of the hands with the recognition of early radiation changes will reveal this. A monthly blood count is the most valuable guide for overexposure of the entire body. Wide separation of cases and rotation of nurses are indicated if there are many radium cases.

- 3—Radium Storage: General body radiation should not exceed 0.1 r per day. Lead or equivalent thicknesses of material like concrete may be used. The protective enclosure and the distribution of the radium therein should be such that a minimum of time is necessary for its identification and removal.

- 4—Manipulation and Preparation: The lead protected table with a lead-lined storage well, the various forceps and clamping devices that will minimize exposure are described in detail. Supervision is necessary to prevent laxness on the part of the technician in the use of protective devices.

- 5—Radon Plants: Danger of inhalation of radon liberated from the radon pumping equipment is minimized by thorough ventilation. At least eight complete changes of air per hour are recommended. Radon seeds and bulbs should be handled immediately after extraction when radioactivity is at a minimum. Automatic pumping is advisable.

- 6—Transportation Within an Institution: The radium should be transported at a maximum distance from the body. The carrier should be built to conform with given specifications relative to the lead thickness and distance of the radium from the handle. If the weight of the carrier exceeds 10 kg., it should be mounted on wheels. The transportation of the radium should be delegated to persons not habitually exposed to radium.

- 7—Transportation by Common Carriers: Shipment of radium through the mails is prohibited. If certain specifications are fulfilled, shipment may be made through the railway express.

Section 8 suggests that unusual conditions be dealt with individually.

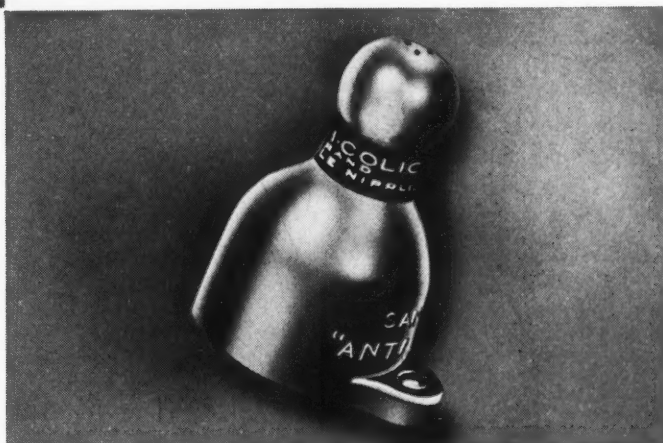
\*Radium Protection, *Radiology*, October 1938. Abstracted by Henry Potozky, M.D.





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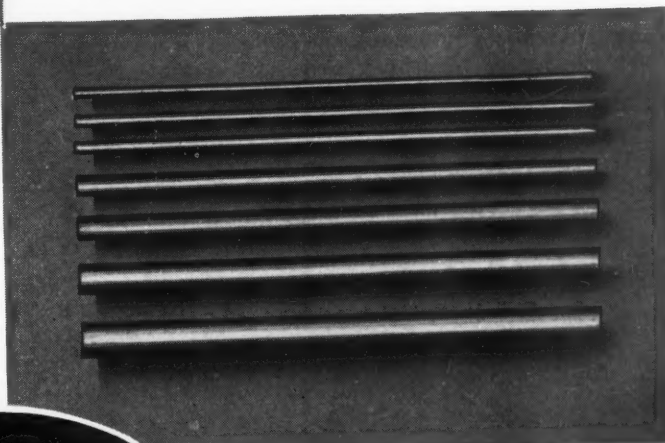
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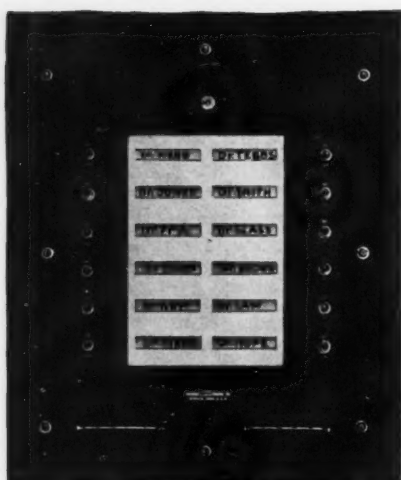
No.	Diam.	No.	Diam.	No.	Diam.
9787	1/4"	9790	1/2"	9793	7/8"
9788	5/16"	9791	5/8"	9794	1"
9789	3/8"	9792	3/4"		



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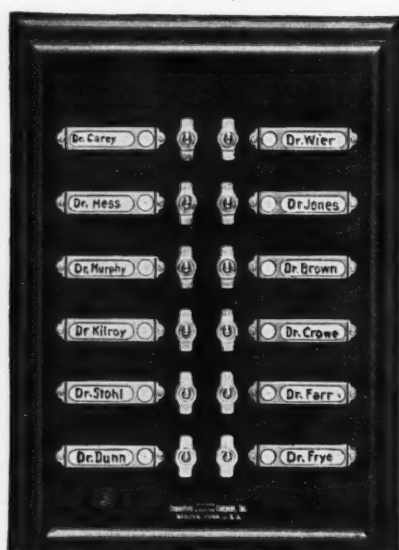


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## BOOKS ON REVIEW

**CLASSIC DESCRIPTIONS OF DISEASE.** By *Ralph Major, M.D.* Springfield, Ill.: Charles C. Thomas. Second Edition, 1938. Pp. 727.

Doctor Major sketches the background of the discovery of many clinical entities and physical signs which cannot but serve as a splendid broadening influence for the practitioner of medicine, the medical student and those with but casual medical training who are interested in things historical. Contained in this book are 403 selections from the original accounts of 190 authorities. The volume is copiously illustrated with 145 cuts from the original monograph, many intensely interesting frontispieces and title pages of the first editions describing the medical condition discussed. Many of these original descriptions, such as those of Hebreiden and Hunger of angina pectoris and of Mitchell on vascular neuroses, stand as classics unimproved by the passage of years.—JOSEPH C. DOANE, M.D.

**JURISPRUDENCE FOR NURSES.** By *Carl Scheffel, M.D., LL.B., and Eleanor McGarvah, R.N.* Second Edition. New York: Lakeside Publishing Company, 1938.

Any nurse who acquires a copy of this book and thereafter attempts to chart her course through legal pitfalls alone and otherwise unaided is likely to get into difficulties. Nevertheless, the work is a valuable effort to acquaint nurses with the legal angles of their professional experiences.

For several reasons, there is as yet no large number of cases at law concerned with nurses in their professional capacities. Statutes requiring examination and registration for graduate nurses are in effect in all states, but relatively few cases in construction and interpretation of the nursing practice acts have been decided by the courts, owing in large part to lack of strict enforcement of the laws. Also, nurses usually are agents instead of principals.

"Jurisprudence for Nurses" is of value insofar as it goes but does not cover the subject as thoroughly as might be desired. For example, chapters are devoted to "Nurses and Contracts" and to "Criminal Responsibility of Nurses," but no similar section is given the torts of nurses, perhaps the most important division of jurisprudence insofar as nurses are concerned.—GRACE PHELPS, R.N.

**THE NEW-BORN INFANT.** By *Emerson L. Stone, M.D.* Philadelphia: Lea and Febiger, 1938. Pp. 291. \$3.

This small volume covers very well the requisites for the care of the new-born, including such prophylactic measures as are necessary to bring a normal infant into the world.

Various chapters review the physiology and development of the new-born, the nursing care, breast and modified feeding of the normal new-born and those with the mild digestive upsets.

The pathologic states of the other systems: spinal, respiration, digestive and urogenital are presented clearly and in sufficient detail for the average reader.

In a volume so up to date, it is strange to see the ineffective preparations of silver being recommended for treatment of gonorrheal vaginitis when its curative and estrogenic treatment originated in the same medical school. However, this slight omission does not obscure the worth of this useful volume.—J. D. PILCHER, M.D.





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"ON Thursday, November 24 (Thanksgiving Day), the Exide unit in this hospital was used again. An emergency operation was performed using the Exide System for 45 minutes. Inspection revealed that the battery was fully charged the following day, having charged automatically, and the unit was ready for further service"—excerpt from an Exide Engineer's report.

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**There's more to a job than doing it.  
Some men and some women give it a drub-  
bing and love it.....how many of those  
do you need?**

*We've lists of "the finest in the land" . . . lists of people for every finer task you have; lists from which you can choose one or two or ten or fifty . . . spunky, eager, smart and pleasant, self-reliant people. Find your personnel from such as those.*

*People make a hospital great.*

*They make it great or they keep it less than it can be depending on the way they do the tasks you give them.*

*Find the finer kind and treat them royally and ask for all they can give and they'll give it, and love the giving, for they would work in stirring times with you and be a part of things well worth their doing.*

*Ask us for such as these. Tell us the kind you need. We will find them for you.*

*For in our files are people . . . they're eager, understanding; they're skillful, self-reliant, self-starters; they're warmly human, smart and spirited . . . we know they are . . . physicians, administrators, staff nurses, dietitians, laboratory workers, anaesthetists, supervisors . . . and they're waiting to be fitted into jobs they would revel in; jobs that would fit them mentally, physically; jobs they would work and smile in, and love, and do better than these need be done, the livelong day . . . for years.*

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## RELAXATIVES

### FOLLOWING IS MY HUMBLE, COMPILED REPLY TO YOUR RECENT LETTER

(Letter received by the credit department of a leading middle western teaching hospital from patient owing \$101.46)

*• Your letter quite recently dated, at hand,  
The message it bears me I quite understand.  
The benign institution that you represent,  
On collecting my bill is eagerly bent.*

*I've accepted your treatment, experienced the knife  
Intended to lengthen an ailing man's life;  
I've eaten your rations and taken your pills,  
Expecting relief from my aches, pains and ills.*

*I've spent many months in your hospital ward,  
Vainly hoping for aid while my bill upward soared,  
Vainly waiting for help that I'd heard could be gained,  
From your Doctors of brilliance and Surgeons so famed.*

*I do not condemn them, they tried to do right,  
They carved off some pieces 'twas causing my plight,  
But each effort seemed futile and time glided by,  
My plight still remained but my bill mounted high.*

*And as time flitted onward my income depleted,  
I compare at the present with a fighter defeated,  
I'd pay my bill quickly and gladly, I swear  
Except for the penury range that's my fare.*

*'Tis like pushing a loaded vehicle uphill,  
Endeavoring our gaunt, empty entrails to fill,  
But I'll try and keep trying as long as I can,  
What more can this dear world expect of a man?*

*It's so easy for men with good incomes or wealth,  
To scorn individuals with poor income and health,  
But I've promised myself and pledged each fellowman,  
That I'll do just the best that ever I can.*

*An' keep hoping that some day the sun will shine  
through,  
And permit me to do what I'm longing to do:  
To pay all my bills and be square with the world,  
And to trek once again with my banner unfurled.*

### Maidenly Modesty

Atlanta, Ga.

• Dear Directress:

I am writing in regard to entering your hospital as a student nurse. . . .

If it is satisfactory with you for me to enter your hospital I will do everything in my power to prove to you that I am indeed interested. If I fail to make the grade I will know what to expect. I don't intend being a failure though. Perhaps I'll be another "Nightingale"—who knows?

Hoping to hear from you in the near future, I remain

Sincerely,

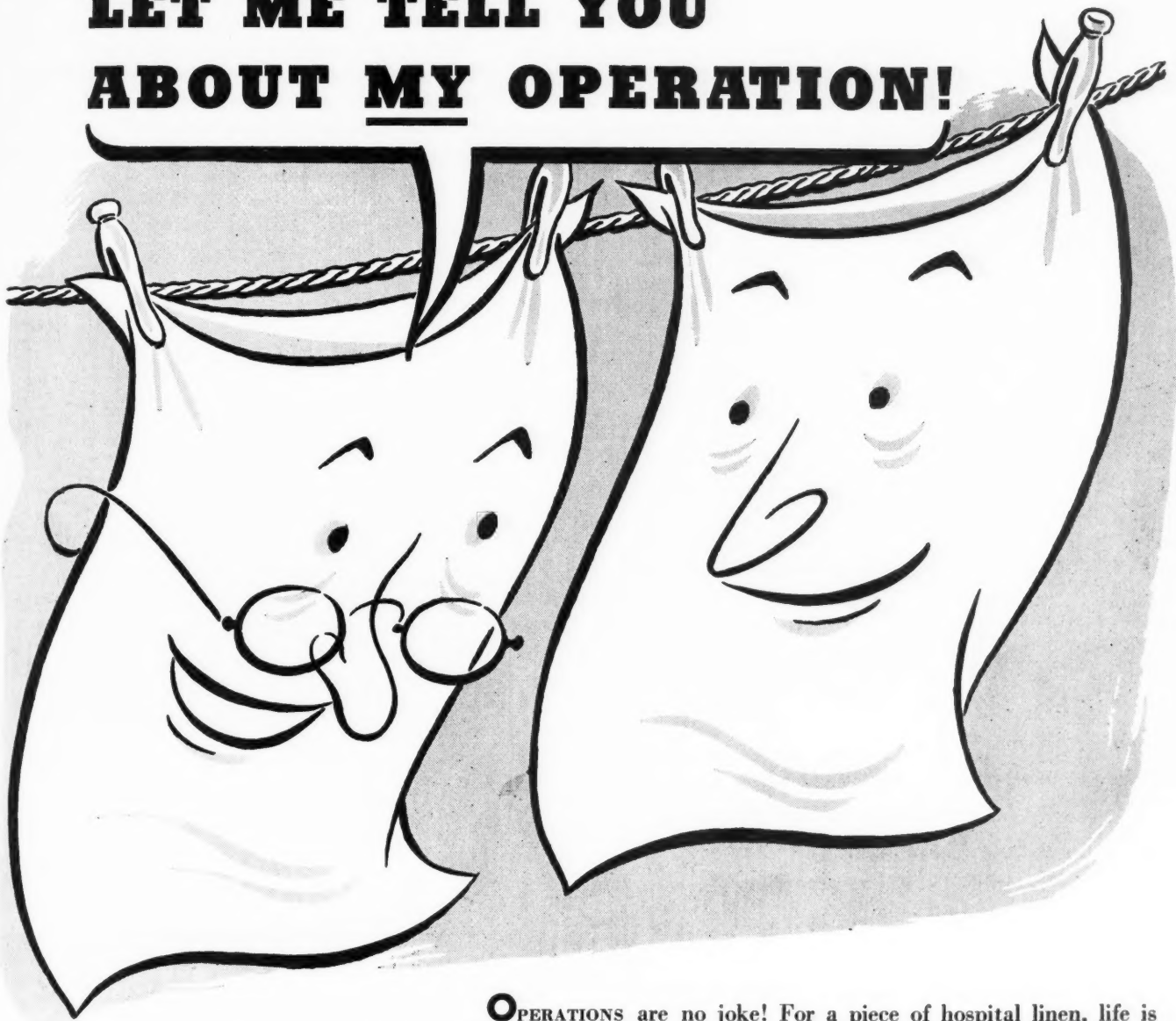
LOUISE JONES.

### Proverbs That Do Not Always Apply in the Hospital

- "Never look a gift-horse in the mouth."
- "Beggars must be no choosers."
- "The more the merrier."
- "What can't be cured must be endured."
- "After a storm comes a calm."
- "What you don't see doesn't hurt you."
- "Everyone is innocent until he is proved guilty."



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**O**PERATIONS are no joke! For a piece of hospital linen, life is just one washing operation after another. Scores of times a year hospital sheets, towels, pads and pillow cases go into the wash wheel. It takes a strong constitution to stand the strain.

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—Sales Offices: San Francisco, California.

## IT'S SAID THAT—

A new ether dispenser, designed for convenience and economy in the application of ether for minor operations or in the removal of adhesive tape, has been developed by the DEVILBISS COMPANY, Toledo, Ohio. . . . The BUTLER PRODUCTS COMPANY, 100 East Forty-Second Street, New York, is introducing a cellophane bottle closure for nursing bottles which is both sanitary and labor saving. . . . A new catalog illustrating and describing the SCANLAN-MORRIS COMPANY'S (Madison, Wis.) enlarged line of SterilBrite surgical furniture is available to hospital buyers.

Both time and temperature are accurately recorded by the new sterilizer control tubes announced by the ARMOUR LABORATORIES, Union Stock Yards, Chicago. . . . The comfort and safety of the patient during the administration of oxygen are increased by the use of the new Lombard inhaler manufactured by the C. & L. LABORATORIES, 450 Sutter Street, San Francisco. . . . CURTIS LIGHTING, INC., 1123 West Jackson Boulevard, Chicago, is offering the Curti-Strip, which makes possible a wide variety of fluorescent lamp installations. . . . A fireproof blanket, so mounted that it can be wrapped around one's body in a few seconds without assistance, is being marketed by the DAVIS EMERGENCY EQUIPMENT COMPANY, 55 Van Dam Street, New York.

Users of 16 mm. motion pictures, either silent or sound, can now have their Kodachrome (EASTMAN KODAK COMPANY, Rochester, N. Y.) reels duplicated in full color and in a quality comparing favorably with the originals. . . . A new open stock pattern of Econo-Rim china is called "Meadowbrook" and is especially designed for institutions. It has been brought out recently by the ONONDAGA POTTERY COMPANY, Syracuse, N. Y.

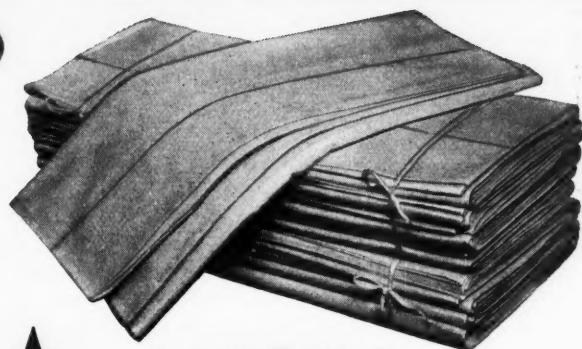
It is now possible to observe the healing of a fracture by the use of the new transparent plastic Lucite splint produced by the plastics department of E. I. DU PONT DE NEMOURS & Co., Inc., Arlington, N. Y. . . . The Dufay film, available from DUFAY COLOR, INC., 30 Rockefeller Plaza, New York, for taking color pictures operates on a new principle that makes it easy to use, requires no special equipment or solutions and gives an exceedingly fine grained result in a few minutes. . . . The Ringo-Westrup perineal heater, marketed by Sharp and Smith, hospital division of the A. S. ALOE Co., St. Louis, provides easy placement of heat in variable degree with comfort for the patient and correct application of the thermal benefit.

In order to improve its facilities for handling business in the Middle West, the CONNECTICUT TELEPHONE & ELECTRIC CORPORATION has opened an office in the Builders' Building, Chicago. . . . The PHYSICIANS' RECORD COMPANY, 161 West Harrison Street, Chicago, has taken over the hospital records department of the Faithorn Company, also of Chicago. . . . Two day technical sales conferences for the purpose of acquainting users of Oakite materials with new developments and improvements in cleaning methods and materials are being held by various service divisions of OAKITE PRODUCTS, INC., New York.



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# Insurance for Indigents

(Continued from page 72)

democratic way of living is the best way. This duplication would also result in an unnecessary amount of extra administrative costs.

A suggestion for further emphasis on the need for medical service and the desire to pay both doctors and hospitals comes from Dr. Donald C. Smelzer, director, Graduate Hospital, University of Pennsylvania, Philadelphia.

I heartily agree with all that you have written in the article "Insurance for Indigents" in the December issue. I also feel that your statements were timely in view of recent developments in Washington.

Perhaps a little more emphasis might have been put on the fact that insurance for the lower income groups, as well as the indigent, must include the service of the physician, and that both the hospital and physician will be paid.

We have been successful in solving our difficulties in the past, and we can solve them in the future if the medical associations will cooperate in the development of insurance or other plans that

will provide complete medical care to all classes of persons, utilizing existing hospital facilities and maintaining the traditional relationship between patient and physician.

The possible complications for teaching hospitals are discussed by Dr. R. C. Buerki, director of study, Commission on Graduate Medical Education, Chicago.

Your suggestion on "Insurance for Indigents" raises problems for the teaching hospitals, if carried out in the precise form that is proposed. They will need to make readjustments to obtain a sufficient supply of patients for teaching purposes.

While medical teaching is important, the adequate care of the sick is even more important. The suggested program for indigents offers promise of improved care for this class of patients. Teaching hospitals, therefore, should and, I am sure, will adjust their programs accordingly.

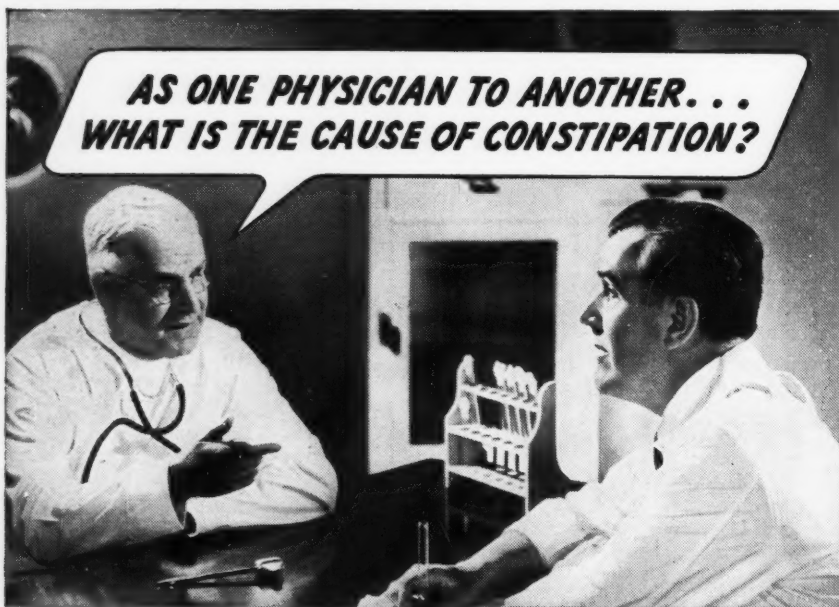
Graham L. Davis of the Duke Endowment, Charlotte, N. C., is willing to carry the integration of

service for self-supporting and for the medically needy even further than has been suggested heretofore.

Your theory that the patient, regardless of ability to pay, should have the best of medical service, including hospital care, is sound. In fact, I went a bit further in a talk I made to the public hospital section of the A.H.A. in Dallas and suggested that the government hospital admitting only patients theoretically unable to pay for hospital care was contrary to American tradition.

I made the further suggestion that the advent of payment for hospital service on the group principle by the low wage-earner, who now pays practically nothing, would change these institutions into hospitals where all types of patients by economic status are admitted. This change for the better would not be as revolutionary as it sounds, since not more than 100 of the great city hospitals would be affected.

Governmental subsidy of group hospitalization for the lower half of the economic heap is sound in principle. It is being done in foreign countries, both in compulsory and voluntary health insurance systems. As for enrollment in voluntary plans of the person so low in the economic scale that he could not pay a small contribution each week, the government paying his contribution for



**O**BVIOUSLY, there is no single cause. Each case must be judged on its own merits. Anatomical differences, variations in diet and habit and specific pathological entities all enter into the cause. However, it is safe to say that faulty habit plays a role in the great majority of cases, and that loss of neuro-muscular tone is a very common secondary factor.

To make habit training easier, a bland, pure mineral oil is important. To increase tonus of debilitated intestinal musculature and nervous system caused by Vitamin B-1 deficiency, pure crystalline Vitamin B-1 has been found to be of great value.

In *Vita Nujol*, these two important aids in the relief of constipation have been combined.

*Vita Nujol* is a smooth, pleasant-tasting emulsion of pure mineral oil with pure crystalline Vitamin B-1 added in such quantity that the suggested average dosage is the average adult maintenance dose of that important food factor (400 International Units).

*Vita Nujol* has a place in the treatment of the majority of constipation cases, and also in the gastro-intestinal syndromes of chronic alcoholism and many other pathological states associated with Vitamin B-1 deficiency.

*Vita Nujol* has been thoroughly tested and proven in laboratory and clinic.

A postal card will bring you free samples and descriptive literature. **Stanco Inc., 1 Park Avenue, New York, New York.**

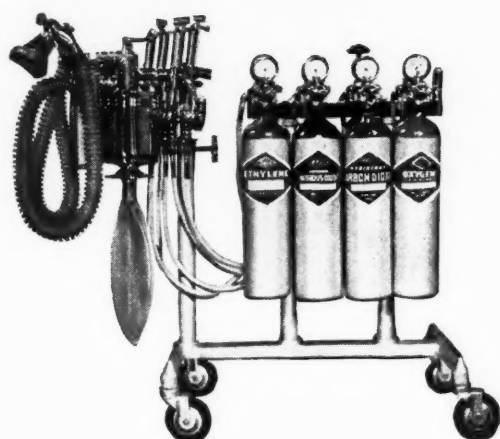
**VITA Nujol**



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# When Humanity Calls...



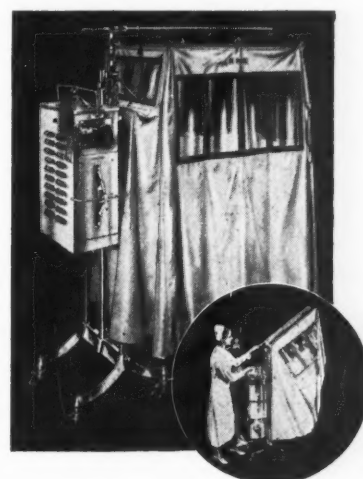
Each day humanity calls at the door of your hospital . . . with the utmost confidence in your ability to cope with any situation and restore health. When the successful recovery of the patient is dependent upon the scientific administration of oxygen and anesthesia, it's mighty important to know that for many years, HEIDBRINK Equipment and OHIO Gases have been recognized by leading physicians, surgeons and anesthetists as the very highest standard of excellence and worthy of the preference which accrues to the leader in their respective fields.

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with its accurate, trouble-free DRY FLOAT Flow Meters is noted both nationally and internationally for its ease and simplicity of operation that enables you to proceed with confidence. No freezing, no filling, no sediment, no cleaning. It's safe, simple, economical and scientifically constructed for a lifetime of service. Available in cabinet, stand and cart models.

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offer every desired feature for successful Oxygen Therapy. The patients' welfare is safe-guarded by the easily and accurately controlled oxygen supply, ample circulation and cooling, the correct limitation of the carbon dioxide and humidity in the oxygen-rich air to be breathed. Claustrophobia is eliminated by the light, roomy hood. There are four models from which to choose. One motorless, three motorized . . . two are portable, for quick transportation. All are highly efficient, positive in functioning, economical, and easily operated without assistance.



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BRANCHES IN ALL PRINCIPAL CITIES

him, that is fine in theory, but I am not certain it would work out well in actual practice. I think it is worth trying. In Great Britain I was told that thousands of people on the "dole" paid their contributions to the voluntary group payment plan each week from these relief funds they received.

I. S. Falk, Ph.D. asistant director, bureau of research and statistics of the Social Security Board and a member of the technical committee that framed the National Health Program, agrees with the principle of a unified service for indigents and others but believes this unification should come about under a compulsory rather than a voluntary system of health insurance.

I think there can be no sound difference of opinion on this point: The aim should be to supply the indigent with the same grade of medical care that is provided to self-sustaining people. There ought not to be one grade of medical service for the indigent and another for the rest of the population.

Furthermore, it would be most desirable to have a unified system of medical care for both groups, so that a person who became indigent could continue to receive service from the same physi-

cian and hospital that had served him when he was self-supporting or that will again serve him when he is again more fortunate.

We have given considerable thought in our division of health studies to the relationships that should exist between medical care for the indigent and a compulsory health insurance plan for the self-supporting. It has been our conclusion that the optimum arrangement would be one wherein indigents would be, in effect, insured persons under the compulsory health insurance plan, with the contributions paid on their behalf by the appropriate governmental authorities. Under such an arrangement, the indigent would be eligible to receive the same medical services and from the same physicians and hospitals as the insured self-supporting population.

C.-E. A. Winslow, Dr. P.H., professor of public health at Yale University, commends the vagueness of the present proposal.

The author has been discreetly abstract in defining what he means by "a unified hospital and medical service for all." How and to what degree? Unified by whom?

This vagueness is very wise, for no one can yet predict how the complex

interrelationships between health department, hospital and physician can best be worked out. There is probably no one solution that fits all cases.

Dr. Fred G. Carter, president-elect of the American Hospital Association, points out some of the practical difficulties that lie in the way of realizing any such plan, no matter how sound.

No one would question the wisdom of establishing a single, coordinated and well integrated plan for medical and hospital service. But the realization of such an ideal is quite another matter. There are entirely too many conflicting elements to overcome or placate. As an ultimate goal to strive for, your ideals are excellent but in a democracy the way to great goals is indirect, compromising and beset with difficulties.

This summary of opinions might well end with a statement from Dr. Lucius R. Wilson, superintendent, John Sealy Hospital, Galveston, Tex.

Discussion of the merits and disadvantages of insurance for indigents, the methods of providing such insurance and the resultant complications could be prolonged for some time. . . . More articles in which various viewpoints are elaborated should prove interesting.

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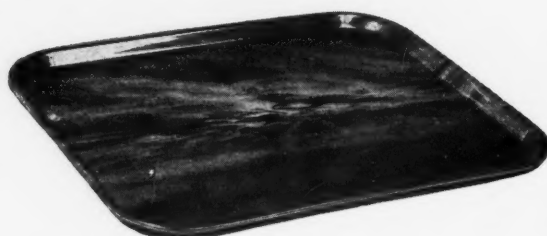
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